CARE

Child Survival X

MARKET NETWORKS FOR COMMUNITY HEALTH

EL ALTO, BOLIVIA

FAO-0500-A-00-4037-00

September 30, 1994 - September 30, 1997

FINAL EVALUATION REPORT

Submitted to USAID on December 18, 1997

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ACKNOWLEDGEMENTS

The evaluators would- like to thank Jennifer Luna of CARE and Carmen Monasterios of CIES, and the staff of CIES/El Alto for their excellent work in preparation for this final evaluation. The quarterly project implementation reports, information from the KPC Survey, the CSX Project auto-evaluation and lessons learned documents were very helpful to the evaluators.

We would also like to express our appreciation to Dr. Alfred0 Machicao, Director of the CIES El Alto Clinic, Maria Elena Daválos, the Clinic Coordinator, and Angélica Caparicon, the health educator. We are most grateful to the field staff: Matilde Sanchez, Belia Cuba, Adela Paredes, Celia Pacari, Adela Kos y Braulio Apaza for their invaluable assistance and insights during the field visits. We specially want to thank Gonzalo Vidaurre, the project driver, who's assistance with transport was invaluable.

Special thanks are in order to Maurice Middleberg, CARE Headquarters Director of Health and Population, and Jayne Lyons, Reproductive Health Coordinator for CARE-Bolivia, whose participation during the first part of the evaluation provided helpful insights for improving project effectiveness.

Finally; the evaluators would like to thank Ileana Baca and Judith Timyan of the USAID Mission in Bolivia for their interest, valuable suggestions, and support of CARE's Market Networks for Community Health Project.

Sandra Wilcox and Lynn Johnson
La Paz, 30 September 1997

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BHIUPVC	USAID Bureau for Humanitarian Response, Office of Private and Voluntary Cooperation
CBD	Community Based Distributor
CDC	Centers for Disease Control
CDD	Control of Diarrhea1 Disseases
CIDEM	Center for Research on Women
CIES	Center for Research, Education and Services
CSPP/JHU	Child Survival Support Program/Johns Hopkins University
DHS	Demographic and Health Survey
DILOS	Direcciones Locales de Salud (Local Health Direction)
DIP	Detailed Implementation Plan
ENDSA	National Demographic and Health Survey
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
KPC	Knowledge, Practice and Coverange
LAM	Lactational Amenorrhea Method (MELA)
NGO	Non-government Organization
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PROCOSI	Coordination Program for Child Survival PVO/NGOs
PROSALUD	Private primary health care organization (nationally based)
PROMUJER	micro-enterprise credit program for women in El Alto
PSI	Population Services International
PVO	Private Voluntary Organization
RHS	Regional Health Secretariat
SOH	Secretariat of Health (National)
STD	Sexually Transmitted Disease
USAID	U. S. Agency for International Development
WARM1	Community strategy for promotion of maternal health and reduction of obstetrical risk
WRA	Women of Reproductive Age

CARE-Bolivia
CHILD SURVIVAL X PROJECT
Market Networks for Community Health
FINAL EVALUATION

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1
SUMMARY AND RECOMMENDATIONS

1. 1 Evaluation Overview

The purpose of the Final Evaluation of the CARE/Bolivia Child Survival Project X Project, "Market Networks for Community Health", is to review progress towards project objectives, identify constraints to the achievement of the objectives, recommend possible courses of action to improve quality and effectiveness, and examine sustainability issues. The results of this evaluation are especially important because CARE has been awarded a four-year follow-on grant to expand and consolidate the benefits of the CS-X Project. The evaluation took place during the 36th month of project implementation, in the cities of La Paz and El Alto, Bolivia, from September 15 to October 3, 1997.

A Knowledge, Practice and Coverage (KPC) Survey was carried out in August 1997, which provided the evaluation team with quantitative data. Qualitative information was provided through structured interviews. Field visits and observations were made of community education activities undertaken by project supervisors including a talk in a factory on sexually transmitted diseases (STDs), a presentation on the control of diarrhea1 disease (CDD) at a community church, and a talk and demonstration of family planning methods for a group of Aymara women. In addition, 15 Community Based Distributors (CBDs) were interviewed individually in their neighborhoods. Interviews were also held with the USAID Mission, CARE/Bolivia staff, CIES national staff, and Population Services International. A final debriefing meeting was held to summarize the results and conclusions and share the recommendations with representatives from USAID, CARE, and CIES.

1.2 Main Achievements and Constraints

Achievements

The CSX Project has increased knowledge indicators in the areas of family planning, STDs/AIDS control and CDD. Contraceptive prevalence has increased from 10.6% to 22% over the life of the project. Knowledge regarding use of pills, condoms, IUDs and rhythm as contraceptive methods has increased by over 10% from the baseline for these indicators. Knowledge levels regarding recognition, transmission and prevention of STDs have also increased significantly among both men and women. The percentage of mothers who know ORT is used to prevent dehydration has increased from 27.7% to 54.3 % over the life on the project.

The CSX Project has improved its management systems including: financial reporting, logistics,

training and education, organizational structure, and supervision. Project staff are devoted, dedicated and committed to working toward the completion of objectives. A network of 194 CBD agents are in place and working efficiently under the guidance of five field supervisors. CIES El Alto Clinic is well run, clean and offers quality referral services to project beneficiaries. IEC programs reinforce educational messages on five local radio stations and a new training manual has been developed for CDD and the STDs/AIDs control manuals are almost completed.

Constraints

Although not as many condoms were sold as anticipated, they are still the main method promoted and distributed by the program. Therefore the method mix being promotedis skewed, with lower levels of referrals for IUDs, pills and vaginal tablets than expected. (Pill distribution has been hampered by national norms that require an M.D. to distribute to first time users). The project only achieved 61% of its continuing user goals. Despite indications of increased knowledge about STDs and evidence of an increasing rate of STD prevalence, there has not been an increase in the number of STD cases referred to the El Alto Clinic. Regarding CDD, there has been no significant increase in the percentage of mothers who have used ORT, which means that approximately one half of mothers in the project service area do not treat cases of diarrhea in their children with oral rehydration therapy. In addition, the percentage of mothers who can recognize danger signs for dehydration is extremely low (24.7%), which means that many diarrhea cases with moderate or severe dehydration are not seen at health services.

There are still some implementation problems with transportation, supervision, organizational structure and linkages between CARE and CIES for improved transfer of technical assistance and management expertise. (See Section 6 of this report for specific issues addressed by the evaluation team.)

1.3 Conclusions Regarding Capacity Building and Sustainability

Both capacity building and sustainability have been enhanced in this project, largely due to the participation of CIES as the institution responsible for project implementation, under the guidance and direction of CARE. CIES has benefited form the partnership in the following ways: improved financial management capabilities; more efficient supervisory system; nation wide expansion of the community outreach program; linkage of CDD to reproductive health programs; and increased capacity for proposal development, baseline and final evaluation survey implementation, and strategic and operational planning.

The national CIES organization receives monies from several donors in addition to generating their own funds through the operation of clinics in several departments of Bolivia. CIES self finances 40% of clinic expenses and 25 % of their organizational budget. This places CIES in a strong position with regard to financial sustainability, especially since the financing from the CARE Child Survival Project is not CIES's sole source of support.

Some 194 CBD agents participate in the implementation of project activities at the community level. The volunteer promoters provide educational services, sell condoms, vaginal tablets and pills, distribute ORS packets, and engage in promotional activities. The community outreach program has contributed to an increase in the number of consultations at the El Alto CIES Clinic, from 6,000 in 1994 to 12,000 in 1996. The increased patient load augments the CIES Clinic cost recovery efforts and sustainability potential.

1.4 Key Recommendations .

Following is a summary of the key recommendations,. Detailed descriptions of the recommendations can be found in Sections 5 and 6 of this report.

1. During the DIP planning session for the new project try to develop a strategy for improving and expanding the contraceptive menu.

2. In order for the CDD component to have more impact on mothers' knowledge and behavior, it is recommended that a census of all children under two years of age be undertaken in a pilot area, for the purpose of enrolling children in the program.

3. Due to the large population in El Alto and the extensive geographic area, mass media should be utilized to promote key messages regarding proper home management of diarrhea in small children.

4. In preparation for the new project, recommend that CIES and CARE project staff work with the CIES personnel department to review and adjust policies for outreach staff that hinder project implementation and negatively impact outreach work.

5. Recommend that project management develop a strategy to improve the transportation situation for project staff in El Alto.

6. In order to maximize the supervisor's time, establish regular monthly meetings with promoters. Provide incentives and pay for transportation to encourage attendance.

7. Hire a full time education or technical advisor to continue working with project staff in order to enhance the continued development of education and training activities.

8. In the new project establish a budget for educational materials to assure a constant supply for supervisors and promoters in the field throughout the life of the project.

9. In the new project analyze obstacles to and explore alternatives for increasing referrals from the communities to the clinic for STD diagnosis and treatment.

10. Reorganize new project management structure so that it is more integrated with the new CIES structure, and realistically reflects personnel time to be spent managing the project.

11. Broaden role of project manager to incorporate innovative CARE strategies from other Bolivia projects into the new project. Promote project accomplishments among donors and work with CIES to develop other strategies for continued funding of project activity, as the CS funding diminishes.

12. CARE should organize an inter-institutional exchange of experiences to integrate the CIES Clinic Program Outreach Coordinator into project activities, and to provide training in improved supervision techniques for the Field Supervisor.

13. CBD Supervisors cannot effectively reach all the areas nor attend to the 194 CBD agents with supervision visits. It is recommended that the project consider elevating the star CBD agents to the level of "Facilitator". The facilitators could receive additional training and incentives, and take on appropriate supervisory duties in specific geographic areas.

2
INTRODUCTION

2.1 Background

CARE officially initiated its activities in Bolivia in 1976, and was primarily involved in the construction of potable water systems. Beginning in 1984 CARE expanded its programs to include latrine construction, community health education, agricultural credit projects, income generation and natural resource management. In 1985 CARE begun work in Child Survival, linking program components with primary health care, basic sanitation, water systems, and community organization.

CARE's purpose is to assist the most needy population groups in developing countries to attain social and economic well being. CARE programs include primary health care, population, food security, girls' education, agriculture and natural resources, small economic development, and emergency aid. CARE works through partnerships with communities, local organizations, the private sector, other international non-governmental organizations (NGOs), and the host country government.

CARE/Bolivia selected two external evaluators with experience in reproductive health and child survival interventions in third world countries: Sandra Wilcox, an international reproductive health consultant who was the team leader; and Lynn Johnson, a public health consultant currently residing in Bolivia. In addition, Maurice Middleberg, the Director of Health and Population for CARE Headquarters in Atlanta was present during the first week of the evaluation. Staff from both CARE and CIES participated in the final evaluation activities. (See Annex A for a list the participants.)

In October, 1994 CARE launched the current USAID funded Child Survival Project, "Market Networks for Community Health", in the city of El Alto, a large urban center adjacent to La Pax, Bolivia. CARE was awarded a three-year grant (CS-X) with a total estimated budget of $782,650. Field costs account for 97.5 % of the total. 84% of the budget is provided by USAID and the remainder is provided by CARE (576,038 from AID and 206,612 from CARE). The Project focuses on market networks to promote family planning, control of sexually transmitted diseases, and control of diarrhea1 disease.

The present Final Evaluation takes place during the 36th month of project implementation. The evaluation took place in the cities of La Paz and El Alto, Bolivia, from September 15 to October 3, 1997. The purpose of the evaluation is to review progress towards project objectives, identify

constraints to the achievement of the objectives, recommend possible courses of action to improve quality and effectiveness, and examine sustainability issues. The results of this evaluation are especially important because CARE has been awarded a four-year follow-on grant to expand and consolidate the benefits of the CS-X Project.

2.2 Project Description

The Market Networks for Community Health Project is implemented in two RSH districts of the city of El Alto, covering 14 zones in District I and 15 zones in District II. El Alto is located at 11,000 feet above sea level on the cold, barren high plain region, called the Altiplano. The city has become a center for rural-urban migration, and is currently the fastest growing city in Bolivia. The population was estimated at 405,492 during the 1992 National Census, and has a current growth rate of 9.2% annually. (See map in Annex A.)

The majority of the inhabitants of El Alto work in the informal sector or are employed in factories. Many work in La Paz as domestics or as day laborers. The educational level of the population is low, a contributing factor in high fertility and infant mortality. According to CARE's 1995 Baseline Survey, only 15% of women of reproductive age (15-49 years) and 27% of men 15 years or older had finished high school. Over half of the women surveyed (58.5%) worked to earn a living working in factories, selling products in local markets, or in handicraft production. Most of the target population are first-generation migrants of Aymara, Quechua and Guarani origin with limited knowledge, practice, and access to health services and information.

CARE has identified a target population consisting of 44,537 women and 42,682 men between 1549 years of age, and 10,949 children age O-23 months. Project efforts are focused primarily on three interventions: family planning, prevention of STDs/AIDS, and control of diarrhea1 disease. Women are beneficiaries for family planning and prevention of STDs/AIDS, men are primarily targeted for the prevention of sexually transmitted diseases and AIDS, and children are the beneficiaries of the CDD intervention.

The original project proposal defined the project area as all of El Alto plus two rural communities. The first Annual Report identified that the project is too small to reach all of El Alto, therefore, the project area was limited to 14 neighborhoods in District I and 15 neighborhoods in District II, plus the two rural communities. The Mid-Term Evaluation recommended not expanding to the rural communities due to the difficulty in implementing the three interventions successfully in both the urban and rural areas, and the need to concentrate more efforts in El Alto.

A new approach for CARE in this project was the decision to execute the project through a partnership with CIES, a local NGO. Originally the CS X Project planned to assume full responsibility for implementation with technical assistance from CIES. CIES was selected as the project counterpart because it is recognized as the major NGO family planning service provider and has been in existence since 1987, with demonstrated successful activities in a variety of

reproductive health services throughout Bolivia. The final collaboration agreement with CIES resulted in a change of strategy, with CIES carrying full responsibility for project implementation, with managerial and technical assistance from CARE. CARE provides the Project Manager, while the rest of the staff are contracted and supervised by CIES. (See Section 4 of this report for information on health infrastructure in El Alto and collaboration activities between the CS X Project and other health institutions.)

Through the partnership CIES will become a stronger organization and better equipped to sustain the market network and community based reproductive health benefits long after the life of the project. CARE will also gain valuable experience through an urban reproductive health project, and learn more about developing successful partnerships with local organizations.

The project design includes the following complementary strategies to achieve child survival and reproductive health objectives: 1) strengthening the capacity of CIES to provide effective services using additional resources and enhanced management systems; 2) community outreach through a cadre of CBDs (community based distributors) who provide education, ORS packets and contraceptive methods to peers; 3) development of an IEC program to promote project interventions; 4) strengthening linkages between community organizations and referral centers, primarily the CIES Clinic.

2.3 Evaluation Methodology

The evaluation responds to the USAID " 1997 Guidelines for Final Evaluation" (Annex **B).** Based on these requirements, the evaluation team prepared an evaluation schedule and data collection forms **(Annex C).**

A Knowledge, Practice and Coverage (KPC) Survey was carried out in August 1997, which provided the evaluation team with quantitative data. (See Annex **F** for the KPC Survey Report.) Qualitative information was provided through structured interviews. Instruments developed for the collection. and analysis of data are included in Annex C). The majority of these were used during the visits to project communities and interviews with CIES administrative and supervisory **Staff.**

Field visits and observations were made of community education activities undertaken by project supervisors including a talk in a factory on STDs, a presentation on CDD at a community church, and a talk and demonstration of family planning methods for a group of Aymara women. Structured interviews wereheld with 15 CBD agents in their respective neighborhoods, and two pharmacies and 2 community physicians were visited. Interviews were also held with the USAID Mission, CARE/Bolivia staff, CIES national staff, and PSI (Population Services International). **(See Annex D** for the list of persons interviewed.) A **final** debriefing meeting was held to summarize the results and conclusions and share the recommendations with representatives from USAID, CARE, and CIES.

3
RECOMMENDATIONS OF THE MID-TERM EVALUATION

In general the project has responded positively in meeting the recommendations from the Mid-Term Evaluation. All of them have been addressed in one manner or another. There are a few items that have not yet been resolved which will be discussed below and in the recommendations section of this report.

1. **Do not expand the project to rural communities at this time. Study the options of expanding to rural areas and/or to growing marginal areas of El Alto as alternatives for a project extension proposal.**

   The project studied the options of either expanding into rural areas or increasing coverage within the existing project districts which were not thoroughly covered due to the extensive areas covered and constant in-and-out migration. The project then received approval from AID/ Washington to not expand into the two rural communitiesas originally proposed. U&AID/Bolivia also supported this decision.

2. Provide training for CIES personnel in:
- **methods and techniques of constructive supervision;**
- **human relations and personnel management;**
- **operational planning;**
- **data analysis for decision making; and,**
- **social marketing techniques to increase CBD sales;**

*** Supervision:** Although a supervision training course was not conducted with the staff, due to its restructuring, CIES did strengthen its supervision system in El Alto. This occurred as a result of the addition of an administrative program coordinator at the clinic who oversaw all outreach programs~including the CBD activity, and an education coordinator. Both of these individuals strengthened and added new components to the existing supervision system.

* **Human relations:** A human relations workshop was not conducted with the staff at El Alto. However, as a result of some of the structural changes made by the project in response to Mid-Term recommendations, human relations did improve at the center. However, with the advent of the CIES restructuring and the addition of new administrative personnel, other problems developed. One of the things that was done in response to this issue was to hold an internal staff workshop and as a result of this the clinic director decided to hold regular weekly staff meetings in which each program was represented and achievements were shared and problems addressed.

In spite of progress in the human relations area, given all the structural changes at CIES, it would be useful to have some on-going attention paid to personnel management. This is being further discussed in the issues and recommendations sections of this report.

*** Operational Plan:** There are now regular planning meetings between project staff and the Clinic coordinator and sometimes with the clinic director. In addition, there are regular monthly planning sessions between project staff and the clinic coordinator. Monthly activities are projected on a form at the beginning of the month and then the results of completed activities tabulated on the same form at the end of the month. These results are then discussed during the monthly planning meetings and activities are outlined for the. next month.

Although the monthly planning meetings appear to be going well and there has been definite progress in the planning of regular program activities, it would still be useful for the CARE/CIES program staff to develop annual operational plans. These plans would include specific annual targets as well as strategies and activities for meeting them. This need will be further discussed in the recommendations section of this report.

* **Data for decision-making:** As a result of this suggestion, the project has implemented a process of better analyzing data pertaining to contraceptive use including new and continuing users, distributions of oral rehydration salts and contraceptives, and numbers and kinds of educational activities conducted. The activity and distribution reporting forms used by the project permit the supervisors to analyze what is occurring with each of their promoters regarding kinds of users and supplies distributed. From this analysis, the supervisors can decide who needs more supplies or who needs help to improve activity in their area.

* **Social marketing techniques to increase CBD sales:** The CBD project personnel received training in marketing and sales techniques. The course was organized by the CIES communications staff. This course was then adapted by the project education coordinator for CBD workers and taught by the supervisors.

3. Provide training in financial management and budget control to the CARE project manager, the CIES deputy project manager, CIES Services Director, and the director of the El Alto Clinic. Also training should be provided to the new CIES project accountant regarding CARE reporting formats and procedures. The CARE project manager and the CIES deputy project manager should receive monthly financial statements of project activity.

Two months after the Mid-Term Evaluation, the project manager and deputy project manager attended a financial management training course (which was a basic accounting course) given in La Paz. In addition, during October of 1996 the project manager attended a budgeting course provided for CARE staff. She also received budget management technical assistance from Jim Becht, the CARE Regional Technical Advisor. The financial management issues

for the project underwent dramatic improvement when CARE opened a regional office in La Paz to assist with project financial administration and CIES hired a new finance director who was better able to facilitate project financial reporting. This is further discussed in the Issues section of this report.

4. **Produce greater supplies of CIES promotional pamphlets and educational brochures for family planning, RH, STD prevention, and diarrheal disease prevention and treatment with ORT. Also order referral forms to be used by promoters. FP and RH materials are available from the IEC subcommittee and JHU/PCS. Pamphlets about STDs and AIDS are being developed by PSI. Suggest reviewing PROCOSI materials to find suitable handouts about CDD.**

   CIES has made available large quantities of promotional cards that are distributed widely by project personnel at markets, fairs, education sessions and other promotional events. There were no family planning or reproductive health pamphlets available when the evaluators visited. However, CIES is supposed to be printing some new brochures. Project staff and promoters complained that these materials have not been available for quite a while. The project has acquired condom use and STD/AIDS prevention pamphlets from PSI and these are used widely. In addition the project did order flyers about specific methods from the IEC subcommittee which were being used by the supervisors but not the promoters. Referral cards were also recently acquired from the IEC subcommittee and the project is determining whether this is an effective system for keeping track of promoter referrals to the clinic (for which they receive and incentive).

5. **The following suggestions are provided to improve the quality of community education:**

   - **revise and limit the amount of information transmitted to low literacy audiences. 5 to 6 messages that can be repeated and discussed per session. Develop written guidelines for this.**

   Project staff received training in how to deliver and reinforce a limited number of key messages to community audiences. This course also included information and practice in using interactive participation techniques. These helped when the supervisors adapted the course for promoters. A manual of this course has also been developed by the education consultant.

   - **incorporate more participatory techniques in the community education sessions.**

   As noted above, the staff did receive training in the use of participatory techniques. The evaluators observed a variety of very creative group interaction techniques used by the supervisors during their visit. Overall the staff's educational skills have improved dramatically since last year.

- **Provide "Capacitando sin Letras" training to staff.**

A shortened version of the "Capacitando sin Letras" (training without 1etters)training was provided to the supervisors and then this training was adapted and given to promoters. Many of the supervisors and promoters commented on the usefulness of the non-written teaching techniques in helping them communicate with their often illiterate community audiences.

- **Provide strong field supervision and follow-up to staff and volunteers for community education.**

- **Arrange for regular technical reviews and updates for both staff and volunteers.**

The project hired an education consultant during the last year of the project who, among other things, designed the education sessions with the supervisors and then supervised their implementation in the communities, providing feedback as needed. The clinic coordinator has also assisted with the education supervision activities. The evaluators noted that the education sessions had been strengthened significantly from the previous year.

As a result of the work of the education consultant and the clinic coordinator, the supervision staff and coordinator have received some on-going technical assistance. In addition, there are irregular meetings with the promoters when updates about different technical information is provided.

- **Develop promoter manual for STDs and CDD. Make additions to family planning manual as needed.**

The CDD manual is in the final printing stages and as yet has not been distributed to the promoters. The promoters do need more reference information about all areas but CDD knowledge appears to be particularly weak.

Regarding the STD manual for promoters, PSI is supporting the development of a series of manuals covering areas such as laboratory management, clinical management, case management and IEC/ counseling. These manuals are being developed by the AIDS project and are still in process. They will eventually include complete packages including manuals, videos, pedagogic design etc. It is thought that the IEC/counseling manual would be appropriate for the educational work of the CBD promoters in El Alto. In addition the CIES AIDS program which is funded by GTZ, is in the process of developing a manual for training promoters which deals not only with education about STD/AIDS but also issues such as violence, self esteem, gender and women's rights. To date neither of these manuals has been completed but hopefully they will be available for the new project. Currently the education consultant is revising the promoter family planning manual. Both the project coordinator and the assistant project coordinator are participating in the revision process.

- Clarify family planning standards of care with CIES medical staff and review standards with project staff.

The CIES assistant program coordinator has been working with CIES services personnel to clarify FP standards of care, as well as standardize family planning messages.

6. **Recommend that the project contract a health education consultant to develop community level modules that have been recommended in the Mid-Term report. These modules are to serve as guidelines for specific key messages to be taught to community groups.**

The project contracted an education consultant during the last six months of the project. She has developed curriculum guides and reports for courses that have been conducted for supervisors and staff and then adapted for CBD audiences. The course topics include gender, LAM (MELA), marketing and key messages. CIES staff worked to develop specific key educational messages for all three project areas (FP, STDs, CDD)and these were then incorporated into the course and in the promotional materials.

It is impressive that CIES took this recommendation seriously enough to develop a whole course on the topic and use it for their staff on other projects. One recommendation is that they continue to reinforce these basic key messages, particularly with the promoter staff, as there are quite a few key messages in the course content.

7. **Prominently display the CIES reproductive health logos on all educational and promotional materials. Provide active promoters with plaques for their homes/shops that identify them as being both CIES and reproductive health volunteers. Supply them with hats and/or other apparel that strengthen their promoter identity.**

CIES has developed a new logo which includes the CIES slogan promoting sexual and reproductive health. Large signs which prominently display the logo have been created identifying the El Alto clinic.

In the health center there is a panel with health messages which also displays the logo. Also the logo is used on all the promotional materials.

The active promoters have signs displayed at their homes/shops which identify them as CIES promoters. They have also received hats, jackets, bags and fanny packs with the CIES logo. Many of these items have been supplied by PSI as part of their condom promotion work with CIES. The promoters have also received "credenciales" with the CIES logo.

8. **Reorganize the supervisory responsibilities of the CBD supervisors by: 1) concentrating the CBD volunteers that they supervise in contiguous zones; and 2) eliminating house-to-house promotional visits thereby allowing more time for promotional activities at fairs,**

markets, and more time devoted to follow-up of active and inactive volunteers.

After the Mid-Term the project did reorganize the promoter supervision system. Rather than have each supervisor oversee activities of promoters located all over the three districts, each supervisor has been assigned specific zones and responsibility for promoters in these zones. They are able to visit and support and recruit the promoters in a more efficient manner. They are also becoming known in their zones and therefore more aware of people and activities.

The house-to-house promotional visits were stopped. Much time was spent on this and there had been little return from the effort (most people weren't home). Instead, the project concentrated on conducting promotional efforts at markets and health fairs in each of the districts. The supervisors make an effort to be aware of all the markets and health fairs being given in the 3 districts and to attend them. This effort was also observed by the evaluators who found it to be well organized, with large promotional panels displaying CIES activities and enthusiastic distribution of promotional materials by the supervisors. The booth was very crowded with interested visitors. Many had heard the promotional media messages on the radio (from the CIES radio campaign) and wanted to know more about CIES's services.

9. **Restructure tbe field team to provide for enhanced leadership and planning capabilities and a better coordinator to supervisor ratio. Current roles are not sufficiently differentiated; one effective coordinator should be able to supervise four or five CBD supervisors; Perhaps one person should be responsible for planning and organizing all community education and/or volunteer training activities. Suggest that the project consider establishing a field director position directly under the assistant project manager who develops the field strategy, provides leadership, on the job training, and develops staff field skills in family planning, STDs and CDD. This person could also balance strategies for reaching both CBD and clinic objectives that are influencing the project.**

After the Mid-Term, the project team was restructured and it was decided that one supervisor coordinator would take charge of the whole team of 5 supervisors. The other coordinator took over responsibilities as the El Alto counselor and also took charge of distributing contraceptive and ORS supplies to the promoters and supervisors. This last had created a huge bottleneck in program efficiency due to the clinic secretary's inability to respond to this task, given all her other tasks. Having the coordinator take over the counseling function that had been another supervisor task, freed them up for more community activity.

After these changes had been made successfully, CIES as an institution underwent a restructuring. The result in El Alto was that a new programs coordinator was added to the clinic staff. This new coordinator took charge of all the field programs including the CBD program funded by CARE. The new coordinator's job was to oversee the planning, organization and follow-up of all these programs. Meanwhile, the CBD coordinator was to be responsible for supervising all the fieldwork of the CBD team. Unfortunately, this new

structural change was not introduced in a participatory manner and has created some confusion regarding actual roles and responsibilities vis-a-vis the CBD program. In addition, both the CIES assistant program manager and the CARE program manager were spending less time at the El Alto clinic, due to other responsibilities brought on by the restructuring. So there was less management attention paid to the integration of this management change in the program. In addition the new clinic coordinator, although she is assuming major responsibility for planning and direction of the CARE funded CBD program, has not really received much of an orientation about the project or about CARE and her salary is completely paid by another donor. The evaluators recommend that this situation be improved with some management adjustments: The clinic coordinator should be integrated into .the program through better orientation and more direct contact with the CARE program manager. Since the assistant program coordinator is not able to spend 100% of her time on the CIES/CARE project (as is budgeted in the project), the clinic coordinator should assume more of the day-today management responsibilities that have been left hanging as a result of the restructuring. The project budget should also be adjusted so that the individuals responsible for managing the project are the ones being paid for it. More about this recommendation is discussed in the recommendations and issues sections of this report.

10. **Resolve transportation problems that staff have in covering field area. There are several options for this in the project budget. One is to hire a driver for the CBD program vehicle in El Alto using the funds allocated for the unfilled project secretary position. This would greatly alleviate the current transportation difficulties and decrease travel time and cost of the CBD supervisors and coordinators to the project neighborhoods.**

The project contracted a driver and this has made a big difference for project efficiency. However, one car and driver can not cover the needs of all 5 supervisors who need to work in different areas, plus the other needs of clinic staff. However, a plan for car use is made on a weekly basis and adjusted for daily needs. The driver is quite able and has taken an interest in helping the 'supervisors with educational activities. The project may want to consider providing technical training to the driver in order to strengthen his abilities.

CIES has an institutional policy which includes all work related travel expenses in the individual's salary. Apparently there is a travel item for coordinators and supervisors included in their salaries. Since CARE has budgeted for transportation costs of supervisors in order to insure that adequate supervision of project promoters occurs, they arranged last year (before the Mid-Term) for supervisors to receive special travel reimbursement. When the evaluators inquired about this situation, seeing the obvious need for improved transportation, they were told that the supervisors filled out the travel forms as indicated - only to be told by CIES that they could not receive further reimbursement for travel. (CIES sets a flat rate for all travel by job category and this is incorporated into the monthly salary. Unfortunately this system does not encourage field staff to spend money on transport, since what they don't spend - they

keep). This presents a problem for the project especially given the limited use of the project vehicle. Perhaps CIES should consider restructuring its travel reimbursement policy for staff that are expected to work in the field between 70 - 90% of the time. The supervisors need to travel to areas that are far from the clinic and they need to be directly compensated for the expense. If CIES wants to build a countrywide CBD program, transportation reimbursement, based proportionately on actual distance traveled, is a key incentive to get people out to the field.

11. **Increase the target number of active promoters to be recruited by the project to 150 (instead of 100). This may require greater recruitment and training efforts and/or more thorough promoter retention strategies.**

According to project records for the last trimester, CIES El Alto now has 162 promoters active in family planning and 130 active in diarrhea disease control, with a total of 194 active promoters. The project staff attribute its ability to recruit these new promoters and retain them to the incentives they have given out through help from PSI, as well as its better organized supervision system, the new training courses and the few group meetings that they have held.

12. **Plan future promotional and community education activities in order to strategically cover currently undeserved areas. Also select and tram new volunteers from currently underserved areas. These three actions should be linked strategically for maximum effectiveness.**

The project has increased many of its mass media promotional activities throughout the project areas. These media activities include radio spots promoting family planning and STDs on Radio Metropolitana and Radio Panamericana. There are also spots promoting CIES and diarrhea control on (the church sponsored) Radio Fides. The El Alto staff (clinic and CBD) also participate in a weekly session on radio Pachamama discussing topics related to sexuality and reproductive health. The same staff also participate on a Monday afternoon program on Radio Integration where they talk about different health topics. In addition, the project has acquired a large screen video player that they take to different communities in the project area and give educational talks and presentations about CIES and the importance of family planning, STD control and Diarrhea control. They also sell condoms at these events.

All of these activities have increased the project's visibility and appears to have helped reach underserved groups through mass media promotion. In addition it appears that the project staff have consciously sought ways to reach underserved or marginal audiences in their project areas and that this objective has been incorporated into their monthly planning sessions. Part of the reason for the staffs effectiveness is their ability to speak Aymara with the community members which opens up more discussion particularly among women who have arrived more recently from the rural areas and who often do not speak Spanish.

13. **Continue the current practice of having supervisors provide one half day per week at the CIES clinic, but organize this half day to include less counseling and more of the following: control of referral slips to assure volunteer recognition and incentives; promote quality assurance for referral patients including translations when necessary; documentation of previous week's activities; planning of subsequent weeks activities; and, providing contraceptives and ORS packets to volunteers.**

As mentioned in the discussion of recommendation 9, after the Mid-Term when the project restructured the field staff, one field coordinator became responsible for all counseling and for distribution of contraceptives and ORS packets. This person also received logistics training from IPPF. The counselor also helps out in the clinic waiting room, giving educational talks, helping patients get service etc.

The program also conducts regular weekly planning meetings with clinic and program staff during which the past week's activities are reviewed and the next week's planned. During the last trimester the project began using the IEC subcommittee (JHU/PCS supported) referral forms to track referrals. Project staff are hoping that this will be an incentive for promoters to refer to the clinic since they receive $bs 5 per referral.

14. **Hold regular monthly meetings with CBD volunteers, by geographic areas. These meetings would be facilitated by the area supervisor with the coordinator. (Meetings for different supervisors and their volunteers would be held on different days or weeks so the coordinator could attend). The purpose of the meetings would be to identify and discuss common problems; provide refresher training and share innovative approaches to specific topics; collect monthly reports; plan the next month's educational and promotional activities; and to develop a mutual support network among the volunteers. Due to the difftculty in getting promoters to come to monthly meetings, would recommend the use of project funds to pay transportation costs and provide refreshments.**

In response to this recommendation, in April of 1997 the project began having irregular meetings with the supervisors and promoters. The meetings appear to be centered around special occasions such as mother's day. They have had an average of 50 promoters at each meeting. The promoters receive incentives such as bags that have educational materials, Pantera stickers, and refreshments paid for by PSI.

So far the project has not organized these monthly promoter meetings as a regular part of the project. Nor have they arranged for project funds to pay transportation for the promoters to attend the meetings. They have used PSI funds to cover the costs of the refreshments. Given the difficulties of supervising 197 promoters, a regular monthly meeting is an appropriate and efficient way to motivate the group. It is also a good opportunity to reinforce and follow-up the training they have received.

15. **Hold regular meetings, perhaps quarterly, between the project manager, the deputy project manager, and the directors of both finance offices to discuss and resolve financial management issues.**

After the Mid-Term Evaluation regular meetings were set up between project managers and the finance offices of both CARE and CIES and have continued through the end of the project.

The project has made tremendous progress in the area of fmancial management. (See discussion under # 3 of this section). The new CARE regional finance office has provided more than adequate service at the project level. The new finance director at CIES and the subsequent reorganization of their finance department has allowed CIES to respond more promptly to CARE's financial requirements.

16. **Re-schedule as soon as possible the inter-institutional workshop to discuss the roles, responsibilities, obligations and procedures of the program and financial departments of both institutions in order to enhance mutual awareness, support and coordination.**

The workshop was not rescheduled because the project financial management problems were handled by the regular meetings of the program managers and representatives of the CIES and CARE finance departments.

17. **Schedule regular meetings between clinic and CBD staff in El Alto in order to improve awareness, expectations and coordination of activities. The field director needs to be involved in bridging the different goals and expectations of the CBD program by clinic staff, on the one hand, and project field staff on the other.**

Regular weekly staff meetings (including clinic and CBD project personnel) were instituted at the El Alto clinic. They are now occurring every two weeks. At each meeting, at least one program is discussed and reviewed.

Although many improvements havebeen made concerning the integration of the clinic and field staff, there is still more to be done. The field director position was never instituted, due to the CIES restructuring and the assumption that some of the functions of the proposed field director were to be absorbed by the new clinic coordinator. However, as noted in the discussion of recommendation # 9, the clinic coordinator has not been integrated into the program, although she has tried to assume some of the management functions (such as planning and organization of the program). If the clinic coordinator is empowered to take over more of the CBD project management tasks and becomes more directly involved in its planning and organization, then the coordinator is the logical person to assume a proactive role in reconciling clinic and CBD program objectives.

18. **Prepare accurate maps of the project areas to facilitate programming and evaluation of coverage. These maps will also be very useful in designing an extension proposal. The maps should identify actual roads, settled residential areas (blocks), the precise location of parks, schools, health posts, churches, factories, community meeting halls, and other key points of orientation. Current information may be obtained from the Military Geographic Institute, the urban planning department of the city of El Alto, and the census maps of the National Statistics Institute. Volunteer or low cost assistance in-preparing the maps may be obtained from university students (thesis projects), or Peace Corps volunteers.**

The project has not been able to obtain a complete updated map of the project area, although they indicate that they did inquire at the offices noted above. Part of the problem is that the districts were restructured shortly after the project began, although the project remained in the same geographical area. It now appears that the new government is going to return to the previous district structure. In either case, it seems that the various official mapping agencies have not kept up with the district changes. However, in spite of this, each of the supervisors has an updated map of the zones and neighborhoods that they work in. Included on the maps are the street names, health centers, schools and churches.

19. **Develop mass media spots or take advantage of spots being produced by other programs for local radio, television and newspapers for the STD/AIDS and CDD/ORT components in order to reinforce messages and expand exposure in the general population. The spots should focus on a few messages for prevention and early diagnosis, as well as direct the audiences to services offered by CIES. Solicit assistance from the PSI and JHU/PCS projects, and also review PROCOSI experiences in order to reduce communications development costs. PSI has an agreement with CIES to strengthen its IEC capabilities, and has also developed radio spots about the prevention of STDs and AIDS which could be made use of.**

In the discussion following recommendation # 12 in this section, we have mentioned the various mass media spots that CIES has developed in the areas of family planning, STDs/AIDS and CDD. We also mention the various radio programs that the clinic and program staff participate in, in the El Alto area. Unfortunately, most of these spots have only been completed and aired recently, so it is hard to measure the impact of these radio campaigns. CIES has also produced some other programs during the year related to sexuality and reproductive health, “Dialog0 al desnudo” and “Historias de1 Vecino”. They have had support from PSI to produce some of these. Also during 1996 and 1997 there have been several television and radio campaigns funded by JHU/PCS which promoted reproductive health services and directed people to several of the IEC subcommittee member organizations, including CIES.

20. **Add practical experiences such as role playing in marketing and sales to the basic family planning conrse for new CBD volunteers. Practice sessions concerning how to sell methods, how to interest clients, how to deal with resistance etc. would allow new promoters to feel better prepared for the job. Could ask PSI to help with this training since they have trained promoters to market their products.**

The project followed this recommendation by developing a course on social marketing sales techniques. They- apparently asked PSI to help with this activity but stated that PSI did not respond. So instead they worked with the CIES communications director who contracted an experienced social marketer who provided a course to CIES staff on marketing techniques and developed a training manual. The project education consultant then adapted this course so that project staff could teach the techniques to promoters. Several of the promoters interviewed during the evaluation commented about the usefulness of this course. It would be good to have some follow-up courses on this topic and to reinforce the messages during regular monthly meetings with promoters.

21. **In order to encourage better contraceptive method mix the project staff needs to stimulate more demand for hormonal methods and for the IUD. At present, CBD staff prefer barrier methods. Suggest that staff and CBD volunteers be given more follow-up education about IUD and hormonal methods, so that they are more comfortable promoting them. Should also explore more or better incentives for promoters who refer patients to the clinic for these methods. Consider allowing promoters to distribute first two cycles of pills before patient has check up at clinic.**

It is interesting to compare the amounts of contraceptive sales and user rates during the last year of the project with the use rates at the time of the Mid-Term (14 months earlier). As had been recommended the project staff did adjust methods projections for the third year. When the proposal was written there had been no experience regarding what they could expect for usage rates when relying on a CBD program, so some of the DIP targets were overestimated and-others such as condom sales underestimated. Although the project did adjust these targets for year three, it is interesting to note that there are still variations. Condom sales were less than projected (106,000 as opposed to 300,000). Project quarterly reports note that sales dropped significantly when the project began relying on PANTERA condoms, the condom promoted by PSI, which is more expensive than the previously successful no-logo condom distributed by the project. In addition, hormonal methods have increased more than projected: pill sales were projected to be 780 this year and have actually been 1074. The project estimated 30 new users of depo-provera and actually had 54. IUDs are still lower than expected.

The project needs to explore better ways to balance the distribution of methods being promoted by the project. PSI has given extensive support for condom promotion. They have provided educational materials, incentives to be given to active promoters, and have supported

meetings and training. PSI has also been active in transmitting media promotion for condom use, and CIES is an active distributor for PSI. So even though condom sales are off from what was projected for year three (due to the CIES decision to only promote PANTERA which is higher cost than the previously sold no-logo condom), it is anticipated that sales will slowly pick up. However, the project needs to find ways to stimulate awareness about the availability of other methods. The project has recently begun using the referral cards (that have a stub so the promoter can keep a record of the referral) to stimulate referrals for IUDs and hormonal methods but it is too early to tell what impact this system is having. Using this referral card should make it easier for the promoter to be reimbursed, and hopefully .will stimulate more referrals for these methods. The project is also exploring the possibility of training promoters to give depo-provera, as a pilot activity. This could make a big impact on its use and has been a successful strategy for motivating promoters in other countries. During the Mid-Term, it was recommended that the project conduct a pilot program which would allow promoters to distribute pills to new clients without first requiring that they receive them at a clinic from a physician. This was not followed up on, due to its conflict with national norms, but could be included as part of the depo-provera pilot as a new activity for the follow-on project. Vaginal foaming tablets also had a very high distribution during year 2 of the project. However during year 3, the price increased substantially and as a result, not as many tablets were sold as anticipated.

Would suggest that during the DIP planning, project staff carefully evaluate why condoms far outstrip other methods being sold to the project target population and is this a provider bias? Obviously CIES has an interest in promoting PANTERA since they are one of its distributers. CIES also has an interest in increasing clinic use but until recently, there was not much of an incentive for promoters to refer patients to the clinic and much of the responsibility for this has fallen on the supervisors to educate at fairs etc. Continued coordination (which was begun in year 3) and joint strategy development between outreach and clinic staff might facilitate this. Contraceptive prevalence has more than doubled during the length of the project (22%) but there is still room to expand and part of the challenge that the follow-on project will be facing in trying to capture more users is: are you offering them what they want? So the question arises: is the target population being offered the variety of methods that it wants? Do they have access to the methods they want? We know from the KPC study that the population knows about contraceptive methods, especially condoms, but are the other methods as accessible as the condom? And would they prefer another method? These are questions that need to be explored when it is discovered that one method is being used more exclusively than others.

4
CAPACITY BUILDING AND SUSTAINABILITY

4.1 Relationship to Private and Public Sector Health Activities

Both capacity building and sustainability have been enhanced in this project; largely due to the participation of CIES as the institution responsible for project implementation, under the guidance and direction of CARE. (See Section 4.3 for more information on capacity of local partners.) As the key implementor of project activities, CIES coordinates with several private and public agencies in the project area to increase both the quality and coverage of health services.

Public Sector Institutions

The project coordinates activities with the Regional Secretariat of Health of El Alto to assure compatibility with national health policies and programs and to avoid duplication of effort. El Alto is one of 12 Regional Secretariats of Health in Bolivia. The RSH in El Alto is divided into 3 districts, two of which coincide with the project's target area. Each District is divided into Health Areas, which in turn operate small health centers, usually staffed by one or two physicians and two nurse auxiliaries. The RSH also operates two District Hospitals in El Alto, " 12 de Octnbre" and "Los Andes". The hospitals offer referral services in obstetrics, pediatrics, and general medicine. The El Alto RSH has a total of 206 staff, including 53 physicians, 8 licensed nurses, and 52 nurse auxiliaries.

The Director of the CIES Clinic, Dr. Alfred0 Machicao, is in close contact with the directors of the RSH, the two Health District Directors, and key staff of the two hospitals. CIES supports the National Health Information System through the presentation of monthly service statistics, and participation in the district CAI[1] meetings for data analysis and decision making. CIES also supports national health programs' sponsored by the RSH and educational events including local health fairs.

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[1] "Comite para el Analisis de Información" (Committee for Information Analysis)

[2] National programs prioritize reproductive health and health of children under five years of age. Interventions include vaccination campaigns, prevention and treatment of pneumonia and diarrhea1 disease, growth monitoring, and reproductive health care (pre and post natal care, deliveries, and family planning).

The project also coordinates with the Municipal government through the District Health Directorate (DILOS). This level of health programming is part of the new Popular Participation Law and is in the process of consolidation. Ideally representatives from public, private and community based organizations should participate in the DILOS, coordinate activities, maximize the impact of health interventions, and avoid duplication of effort.

Non-Povernmental Organization

NGOs which provide health services in El Alto include CIES, PROSALUD, and PROMUJER. The Dutch government sponsors a primary health care project (APS), which concentrates on strengthening the RSH through training and inter-institutional coordination. PROSALUD operates 6 clinics in the project area, providing basic health services including family planning. PROMUJER works with women's groups and provides information and education on reproductive health topics. Other organizations which target individual women and groups for overall assistance in various gender issues are Gregoria Apaza and CIDEM. In addition to the above, the Municipality of El Alto sponsors 4 health centers, there are 4 church supported clinics, and 4 private clinics.

The project has a formal agreement with PROMUJER. CIES provides free checkups and pap smears to members of the women's groups, plus educational services. The volume of new patients from the groups and their use of CIES laboratory services makes this agreement profitable for CIES. CIES coordinates education, promotion and counseling activities with Gregoria Apaza and CIDEM. In addition to work with the RSH and NGOs, outreach activities are implemented through local church groups, factories, sports organizations, "juntas vecninals", and local markets and fairs.

To further improve inter agency cooperation, CIES is a member of the El Alto Inter-Institutional Health Committee. The CIES El Alto Clinic Program Coordinator is a member of this committee, which meets every two months to exchange experiences, share information, and plan innovative strategies for promoting womens' health.

4.2 Sustainability Status

CARE has been awarded a follow-on grant from BHR/PVC for an additional 4 year cycle. The new project will continue to strengthen CIES as an institution, expanding the outreach program to include work with men, pharmacists, private physicians, and womens groups in the WARM1 methodology.

The national CIES organization receives monies from several donors in addition to generating their own funds through the operation of clinics in several departments of Bolivia. CIES self finances 40% of clinic expenses and 25 % of their central office budget. This places CIES in a fairly strong position as regards financial sustainability, especially since the financing from the

CARE Child Survival Project is not CIES sole source of support. The new project calls for a gradual decrease of BHR/PVC funds with a subsequent increase of funds from other donors over a four year period.

In addition to CARE, CIES El Alto receives financing form several other donors. Population Services International pays the salary for the El Alto Clinic Program Coordinator, and provides IEC materials on family planning and STDs, and incentives for project staff and volunteers geared towards the promotion of Pantera condoms. GTZ currently covers some of the costs for work with STDs, including laboratory equipment and training. CIES is in the process of becoming an IPPF (International Planned Parenthood Federation) affiliate, and, as such has received extensive training and orientation in administrative systems, family planning logistics management, and financial support for operational expenses (approximately 55 % of CIES yearly budget).

4.3 Capacity of Local Partners

The CARE-CIES partnership has been a new and exciting arrangement for both institutions. CARE has a global policy directed at enhancing its work through partnerships with other organizations and CIES was interested in strengthening its own institutional capabilities through its work with CARE. At the time the partnership was proposed it was thought that the indirect benefits of the partnership were that CIES would become a stronger more viable organization and gain experience in working in diarrhea1 disease control and CARE would gain experience working in urban areas, in reproductive health, and in learning the advantages and disadvantages of implementing projects through partnerships.

At the time of the Mid-Term Evaluation, a viable and effective working relation seemed to have been established between the two organizations and this has continued and been strengthened through the end of the project. The first two years of the project saw many administrative adjustments and negotiations required in making the partnership work. The major issues centered around the internal interests and autonomy of the two organizations, and meeting CARE's contractual obligations with AID.

One of the issues in implementing this project through a sub-agreement arrangement is that the CARE project manager (the only full time CARE staff person) is responsible and accountable to CARE for all project resources and results, but she has no direct authority over CIES's project staff nor its management of resources. While the CARE project manager has a legitimate role in overseeing, monitoring and contributing to project implementation, CIES personnel are accountable within their own organizational structure and operating policies. Thus CARE's influence resides in the precision and clarity of the subcontract, obtaining agreement to strategic objectives, mutually agreed upon annual and quarterly operational plans, clarity and respect for roles and responsibilities, and ultimately on the strength of human relations, good will, and mutual respect of the individuals involved.

Both institutions have considerable experience in implementing health projects and in managing finances and program agreements from diverse donors. The organizational structures are found in Annex F. CIES staff have considerable experience in family planning and reproductive health. CIES provides these services through 10 regional centers in the major cities of Bolivia. CIES field staff are experienced in working with volunteers and community groups.

At the time of the Mid-Term there were two project management areas that needed attention. The first was the inadequate financial management capabilities of both the CARE project manager and the CIES deputy project manager. The second was the inadequate structure, leadership and operational planning capabilities of the field coordinators and supervisors team in El Alto. The members of the Final Evaluation team found that most of these problems have improved.

As is noted in Section 3 of this report, which reviews the Mid-Term recommendations, both finance departments underwent structural improvements and changes that allowed them to pay more attention to project finances and bring them up to date. For full information on the financial status of the project please see Section 6, issues identified by the evaluation team. The second management area which dealt with the structure of the project team, also underwent improvement.

As is discussed in Section 3 of this report, the project did restructure its team and the corresponding work areas for team members in accord with Mid-Term recommendations. However, soon after this project restructuring, CIES underwent a reorganization that has created new management structures in El Alto, by adding a deputy manager (programs coordinator) for the clinic who, among other things, is responsible for all planning and coordination of the CBD program with the other El Alto programs. While on paper, this is a highly desired management change from the CIES and the project's perspective, in practice this new coordinator (who is paid by PSI) has not been well integrated into the CARE funded CBD program and therefore has not assumed many of the management responsibilities needed to strengthen the leadership and operational planning capabilities of the field coordinator and supervisors. At the same time, the CARE project manager and the CIES assistant project manager were spending less time overseeing day-to-day management of the project, so they were not available to facilitate the integration of this new manager into the project. So for the follow-on project it is recommended that this issue be resolved. (See Section 6 of this report).

The DIP states that as a result of this project "CIES as an institution will be strengthened through improved monitoring, evaluation and supervision systems for the CBD program." (p.23) The CARE-CIES sub-agreement goes further by stipulating that CARE will strengthen CIES by improving its information and supervision systems, training project staff in the development of the information and supervision systems, training staff in documenting (CBD) activities, and providing technical assistance to improve financial management and reporting. In practice, the institutional strengthening has gone both ways, with CARE learning a great deal about working in partnership and about urban programming.

Significant progress has been achieved in developing the project information system (see Section IV.B of Mid-Term Evaluation) and in financial management capabilities (see Section 3.3 above). While some progress has been made in improving the CIES supervisory system for the CBD program, it is thought that CARE could provide additional technical assistance to strengthen this aspect (see Section 6 of this report). One of the areas that the project has strengthened for CIES, that was not anticipated, is that it has provided them with an experience base from which to consolidate and expand its CBD program nation-wide. In another area, the child survival project has also allowed CIES to link diarrhea1 disease control activity with family planning and reproductive health.

Some ways that CARE has contributed to CIES's institutional strengthening include: articulating and systematizing procedures and practices; improving the organizational structure regarding the CBD program; proposal development for PROCOSI financing and follow-on funding for this project; quantitative techniques for baseline survey, KPC and evaluation studies; providing models and training for detailed implementation planning (DIP). CIES has already been working on many of these areas but this project has allowed them to be strengthened and expanded.

4.4 Community Participation

Over 190 volunteer promoters participate in the implementation of project activities at the community level. The promoters provide educational services, sell condoms, vaginal tablets and pills, distribute ORS packets, and engage in promotional activities. During both the Mid-Term and Final Evaluations, the promoters shared their successes and concerns with the evaluators, and made valuable recommendations for improving the scope and quality of the community outreach program.

The main focus of project activities has been health education and promotion through the work of CBD volunteers, educational activities undertaken by CIES staff and promoters, evening film sessions in local neighborhoods, and radio spots and programs. All of the promoters interviewed during-the Final Evaluation mentioned the success the project had had in reaching people with health information and services. Community members and promoters expressed a need for more information, education and training regarding project interventions. Community demand for project activities to continue can be seen in the steady increase of users of family planning methods (mainly condoms), the increase in the distribution of ORS packets, and the rising number of community members who utilize the CIES Clinic.

The communities provide human resources who volunteer their time to attend training sessions and later to promote project activities. Many of the CBD agents also offer their homes as local distribution centers for condoms and ORS packets. The provision of incentives and regular supervision are important factors in keeping the CBD agents motivated and active. There are currently 194 active CBD agents, up from 100 a year ago. During this last year of project implementation, attrition of volunteer promoters has greatly improved: it was 17%, down from

41% a year ago. This improved retention rate is a notable achievement for any program that relies on volunteers.

4.5 Cost Recovery

The CIES Clinic in El Alto generates income to cover operating costs. Patients pay for consultations and are also charged a fee for laboratory, dental, sonogram, and delivery services, plus pharmaceuticals. Cost recovery for 1996 was 58 % , an increase of 11% since project start up in 1994. The number of consultations has doubled in two years, 6,000 in 1994 to 12,000 by 1996, and is expected to be even higher for 1997. The sale of contraceptives provides some cost recovery, and is also an incentive for the volunteer promoters who sell condoms and other methods at a small profit. (1 Boliviano for a package of two condoms).

4.6 Capacity Building and Sustainability Plans and Outcomes

The following chart shows the project's sustainability goals, as described in the Mid-Term Evaluation Report, steps taken, and outcomes.

GOAL	END OF PROJECT OBJECTIVES	STEPS TAKEN TO DATE	OUTCOMES
A) CJES assumes full responsibility for project implementation	1. CJES will develop and carry out project implementation plan. 2.. CIES will execute and account for approved project budget expenditures.	1. Regular CARE-CJES meetings to reprogram activities and execute the budget 2. Streamlining of CARE's financial reporting requirements and CJES financial system 3. Restructuring of the field team to improve leadership and planning capabilities 4. Reorganization of supervisory responsibilities of CBD supervisors	1. Project activities successfully implemented by September 1997. 2. CIES financial reports turned in on time and disbursements from CAPE to CJES made on a regular basis. 3. The full budget was spent by September 30, 1997. 4. All projected activities were implemented by CIES Staff.

GOAL	END OF PROJECT OBJECTIVES	STEPS TAKEN TO DATE	OUTCOMES
B) Community members will continue to demand family planning, STD and CDD/ORT services and supplies.	1. CIES will provide community-based promotion and education activities. 2. Local mass media will transmit public awareness and information messages on FP, STDs and CDD/ORT .	1. 1135 group community education sessions were held 2. 12,878 community members participated in the education sessions 3. Radio spots and programs aired on.5 local stations, large screen video projections in neighborhoods, distribution of flyers produced by PSI on PF and STD control, and promotional flyers for the CIES Clinic	1. 475,711 condoms sold, and 14,507 new users 2. 1,676 pills sold 3. 29,869 vaginal tablets sold 4. Referral to CIES Ciinic: 615 for IUD, 588 for first time pill, and 486 STD cases 5. Counseling sessions in CIES Clinic: 2,591 women, 196 men, and 831 couples 6. Clinic volume doubled.(6,000 - 12,000)
C) CBD volunteers and the CIES clinic will continue to provide quality FP. STD and CDD services and supplies.	1. CIES will supervise and provide refresher training for 125 CBDs 2. CIES will obtain and distribute sufficient supplies of contraceptives and ORS packets.	1. 721 volunteers recruited 2. Training courses in FP. STD CDD, social marketing, domestic violence, participatory education techniques, and education for illiterate people 3. Reorganization of logistics system at CIES Clinic	1. 194 active CBDs in place 2. 4.526 ORS packets distributed 3. 507,256 contraceptive methods distributed

Following are the sustainability goals and objectives for the follow-on project:

Goals

1. Project beneficiaries will continue to practice health seeking behaviors with respect to the 4 project components.
2. Women and men of reproductive age will continue to demand services in DCM, high risk obstetrics, STD control and birth spacing.
3. CBD volunteers, community physicians, pharmacists and the CIES clinic will continue to provide quality services in DCM, high risk obstetrics, STD control and birth spacing.
4. CIES will continue to provide institutional support of the health network and will assume full responsibility for implementation after USAID funding ends.

Objectives

1. Target populations will achieve expected changes in knowledge, practices and coverage in child survival interventions.
2. Neighborhood councils will be active and continue participatory planning for health problems.
3. CIES will select, monitor and sustain 100 CBDs, with no greater than a 30% dropout rate.
4. CIES will select, monitor and sustain 8 community physicians and 15 pharmacists.
5. CIES will maintain a basic information system for monitoring activities and informing the network.

5
DISCUSSION OF FINAL SURVEY FINDINGS

5.1 FAMILY PLANNING

Problem Statement

Maternal mortality rates in Bolivia are among the highest in Latin America. The 1994 DHS reports a rate of 390 per 100,000 live births for the country. The problem is even more serious in the Altiplano region, where maternal mortality is reported at 656 for rural areas and 399 for urban centers. Social and biological factors that contribute to maternal mortality include: pregnancies for women under age 18 or over 35; short intervals between pregnancies (less than 24 months); poor or non-existent prenatal care; lack of tetanus toxoid vaccination; home delivery in inadequate conditions; and induced abortion. Early pregnancy rates are high: 40% of girls age 19 are already mothers, and 9% of these have at least two children. As much as 50% of mothers have intervals of less than 24 months between pregnancies. For the Altiplano region, 66% of mothers have not been vaccinated with tetanus toxoid, and 70% have home deliveries under less than adequate circumstances. Women of Aymara and Quechua origin are not likely to seek modem health services due to poor treatment on behalf of health personnel, embarrassment during examinations by male physicians, little confidence in the ability of modem practitioners to cure diseases; and a lack of fmancial resources.

Data from CARE's 1995 Baseline Survey in El Alto indicated that 78.3% of women of reproductive age (WRA) did not want more children or want to postpone the next birth for more than two years, however only 8.7 % were using a modem contraceptive method. For those women who were not pregnant and did not want to have children or want to postpone the next birth, the majority (89.4%) were not using a modem contraceptive method. In spite of the low use of modem methods, many women knew of at least one method (81.7%): 70.2% had heard of contraceptive pills, 58.7 % knew about condoms, and 65.2 % have heard of IUDs.

Proposed Strategy

The family planning component has sought to increase modem method contraceptive prevalence by: identifying and training CBD volunteers; referral of beneficiaries to the CIES clinic by volunteers; providing direct services through the CIES clinic; providing IEC through mass media and community based activities; supervision and resupply of volunteers; counseling, referral and methods through the volunteers and counseling, reproductive health services and methods provision through the clinic.

Training sessions were developed about family planningmethods and counseling techniques. Initial training was provided with refresher courses offered every 6 months. Continuous services were provided by CIES staff and volunteers. The resources available to the program include services at the CIES clinic, training materials, contraceptive methods, and supplies for PAP smears.

Findings

The following chart compares the project objectives to the results of the baseline (mentioned above) and the final KPC surveys. The KPC survey is a population-based survey that shows endencies in the broader project population area, not just the project population.

INDICATOR	GOAL	BASE-LINE 1995	KPC JULY 1997	% in-crease
% of women of reproductive age who are not pregnant, who desire no more children in the next two years and who are using a modern contraceptive method	20.0	10.6	22.0	12
% of women of reproductive age who have knowledge of at least three modem methods of family planning	90.0	61.7	78.7	17
% of women of reproductive age who have knowledge of pills as a contraceptive method	90.0	70.0	82.2	12.2
% of women of reproductive age who have knowledge of condoms as a contraceptive method	90.0	59.0	76.4	17.4
% of women of reproductive age who have knowledge of IUD as a contraceptive method	90.0	65.0	78.3	13.3
% of women of reproductive age who have knowledge of rhythm as a contraceptive method and know that a woman is most fertile half-way between menstruations.	60.0	14.0	29.1	15.1

Achievements

1) The biggest achievement in the area of family planning is that the project superceded its goal of increasing contraceptive prevalence from 10.6% to 20%. Actual figures indicate that the CPR in the project area at the time of the final KAP is 22%.
2) Knowledge of at least 3 modem methods of contraception among women of fertile ages increased from 61.7% to 78.7% during the project period.
3) Knowledge about pills as a contraceptive method increased among women of fertile ages from 70% to 82.2%.

4) Knowledge of condoms as a contraceptive increased from 59% to 76.4% among women.
5) Knowledge of the IUD as a contraceptive increased from 65% to 78.3% among women.
6) Knowledge of rhythm as a contraceptive method increased from 14 % to 29.1% among women.
7) All the CBD workers interviewed by the evaluators could name and explain how to use the different family planning methods promoted by CIES (condoms, vaginal tablets, pills, depo-provera, IUD and rhythm).
8) CBD volunteers referred to CIES those clients that wanted hormonal methods (pill, Depo-provera) or the IUD. The project is now using IEC subcommittee referral forms which have a stub so the promoter can keep track of her/his referrals to CIES (for which they are given an incentive). It is anticipated that use of this new form will increase referrals.
9) All of the CBD workers interviewed received at least 2 supervisory visits per month from their corresponding supervisor. During these visits, the supervisor reviewed reporting forms (and filled them out for the promoter if she was illiterate), resupplied the promoter with contraceptives, answered questions and provided follow-up education as needed. There did not appear to be a problem with supplies.
10) Supervisors and promoters conduct community education sessions about family planning in their zones. Project data shows that they superceded their goal of providing 200 educational sessions on family planning during year 3 and actually conducted 302 (151% of goal) (see Annex G for process indicators). The staff conducted well organized sessions using flipcharts and models as well as diverse participatory techniques. They also focused on providing a few key messages that the participants could remember. The educators ended the sessions by distributing educational brochures about the discussion topic and by distributing promotional flyers about CIES and it's location.
11) Recently CIES has begun a radio campaign on two national stations (Panamericana and Metropolitana) which serve El Alto. These broadcast information about family planning and refer listeners to CIES. During 1996 there were two large media campaigns conducted through television, radio and billboards which were supported by JHU/PCS and by PSI. These campaigns also referred people to CIES as well as other organizations.
12) All the promoters interviewed had prominently displayed signs identifying their home or work place as a CIES post. The active promoters also had jackets, caps, fanny packs and bags with the prominently displayed CIES logo identifying them as CIES promoters. The promoters were very pleased by these incentives and were proud to represent CIES.
13) The family planning educational sessions discuss standardized key messages about the couple's right to plan a family, the need to space births, the importance of having pregnancies between the ages of 18 and 35 years, the fertile period of a women's monthly cycle, family planning methods, where information about FP services can be obtained, information about CIES services and locations.
14) The CIES clinic provides services for patients that are referred from the communities.
15) The CIES staff regularly attend health fairs and markets in order to promote CIES's services and provide information about family planning, STDs and diarrhea control. The staff have created large display panels which describe these services.

16) CIES has a good information system which keeps track of new and continuing family planning users of the CBD program. The system also includes indicators for numbers of condoms, pills and vaginal tablets distributed (see Annex G) and it documents referrals to the CIES clinic for IUDs and hormonal methods.

Concerns:

1) Method mix: Although condom sales are off from what was projected by the project, which CIES staff believe is due to the CIES decision to only sell the more expensive PANTERA condoms, they are still the main method promoted and distributed by the pro-. gram. Therefore the method mix of CBD users reflects the supply. Does this reflect a CIES policy to promote PANTERA over all other methods, or is this a user preference? Although referrals for depo-provera are more than was expected, they are still low (30 new users, 40 continuing users). IUD referrals are also lower than expected (208 instead of 360) and vaginal tablet sales are much lower than projected (3002 versus 10,000). It is unclear whether the project has fallen short of its projected condom and vaginal tablet sales goals because of the stricter and more controlled logistics system that was implemented during the year or whether this is due to the condom price change referred to above and a dramatic price increase from 15 centavos to 70 centavos per vaginal tablet. (see PF user chart Annex G).
2) CIES personnel policies: Although the supervisors try to visit each promoter assigned to them (30 per promoter) at least twice a month, transportation is still an issue. Because there is no transportation reimbursement system at CIES that encourages staff to go to distant areas, there is a tendency to concentrate on more accessible sectors. The jeep donated to the project by CARE has been a great help to the project but it can not transport all 5 supervisors to each of their work areas at the same time! Another concern is the personnel policy of having all staff punch time cards at the clinic in the morning, before lunch, after lunch and at the end of the day. This requirement encourages staff to leave work half done in distant communities in order to get back in time to punch out for lunch.

Discussion and Conclusions

Effectiveness

Judging from the increase in contraceptive prevalence as well as the increases in knowledge about family planning methods in the project area, the project is being effective in improving women's and children's health. In addition, the project superceded most of its new user projections although it only achieved 61% of its continuing user projections. Although the project did not achieve the knowledge levels about family planning methods that was anticipated in the detailed implementation plan (DIP), the knowledge increases do appear to be significant. The expectation of increasing knowledge about contraceptive methods from 60 - 70% to 90% of the population may have been overestimated.

The education and promotion strategies are also much better organized than at the time of the mid-term evaluation, and these strategies have contributed to increased knowledge among the project population. The increased emphasis on training of promoters and the new training courses on key messages, "capacitando sin letras techniques" and social marketing techniques seems to have strengthened promoter retention as well as increased recruitment of new promoters.

Relevance

All of the project activities which include: the educational and informational presentations; the mass media educational spots and talk show discussions; the training and implementation of a network of community based distributors; the on-going supervision and follow-up training of the promoters; has contributed to the increased knowledge about family planning and the increased use of these services among the population in El Alto.

In conclusion, the project is contrbuting to greater awareness about and increasing use of family planning services in El Alto. It is important that this project will be continuing for another four years with the follow-on project and expanding its areas of focus. Given the positive effect that the project has had so far, one can assume that this will only increase when its activites expand under the new project. As noted above there are a few concerns about the present operation of the project. Recommendations addressing these concerns and other suggestions are noted below.

Recommendations

1. During the DIP planning session for the new project try to design a strategy for improving the method menu offered in the project. There is a good possibility of receiving funding through FHI that would allow CIES to train promoters to provide depo-provera injections to interested users, as a pilot program (which will allow it to be approved by the MOH).

2. If the project staff decide to go ahead with the pilot study above for training promoters to provide depo-provera injections to users, they might also include the distribution of the first couple of cycles of pills for interested pill users as an additional part of the pilot study, or as a separate study. This was suggested during the mid-term evaluation as a method for increasing pill use but CIES could not get the SOH to approve it. However, it has more liklihood of being approved as a pilot study. The promoter would distribute the first couple of cycles to the new user and then ask the person to go to the clinic for a check once she was established as a method user. This was suggested because the CIES Director of medical Services thought that the requirement that the first pill cycles be obtained at the clinic after a check-up, was a barrier for increasing pill users. Both of these recommendations would be an incentive to the promoters to increase distribution of hormonal methods.

3. In preparation for the new project it is recommended that the project staff work with the

CIES personnel department to encourage adjustment of some of their policies for community outreach staff. (This seems like an important move given CIES's expressed desire to expand CBD programs to all its centers in Bolivia). One recommendation would be to remove the transportation allowance from the field staffs salary and set up a standardized reimbursement policy and proceedure for distances actually traveled during a performance period. This system would provide more motivation for field staff to travel more regularly to remote areas. Another area that the personnel department should review is the requirement that field staff punch timecards four times a day. This policy is interfering with community supervision and education activities, since it often requires.that the staff conduct these activities during the lunch hour or in the evenings.

4. As mentioned above, the car donated to the project by CARE, after the mid-term evaluation, has been of great assistance in facilitating education and promotional activities. It is also useful when the supervisors need to conduct activities in pairs. However when each of the 5 supervisors has to go to a different place, it is not so useful and then each one has to find their own way to get to the required location. Much of the car and travel logistics are hashed out in the monthly planning sessions with the clinic coordinator and the most appropriate plan is drawn up. The evaluators saw that maximum use was being made of the project vehicle. The driver has also been a great addition to the staff and he often helps out with the education activities. The clinic director and assistant project manager have asked CAFE if it would be possible to get a couple of motorcycles to give the staff more mobility. (This might require that CARE also provide training to the female supervisors regarding how to operate the vehicles). CARE is in the process of analyzing the availability of motorcycles for this purpose. If this is possible, the evaluators see that the motorcycles could be very useful in facilitating the work of project staff, given the huge travel requirements that they have to be effective supervisors. The clinic director and evaluators agree that the availability of a motorcycle for the one male supervisor would be very useful, because he works in all the project zones visiting factories and male promoters in his work with men.

5. In order to make better use of the project supervisor's time, the evaluators would recommend that the project establish regular monthly meetings with promoters whereby reports could be reviewed, supplies distributed, educational updates and reinforcements provided, and special incentive activities could be conducted, such as prizes for the most sales, most referrals etc. This was recommended at the mid-term but was not implemented as a monthly meeting (instead the meetings were offered for special ocassions), nor was travel reimbursed for promoters, so many did not come. It is recommended that the project staff consider these meetings for the follow-on project and that they reimburse promoter travel expenses and provide refreshments so people will come.

6. Although the monthly planning sessions seem to be keeping activities on track, and the

weekly staff meetings between clinic and project personnel is helping to smooth out administrative issues, there is also a need for longer range operational planning, where some of the strategic project objectives can be operationalized. Suggest that during the DIP process, staff set up a schedule for the development of yearly operational plans whose status can be reviewed periodically and discussed at the monthly meetings. This longer range focus will help keep project staff oriented to the larger project and CIES goals. If the Clinic Coordinator takes on a more active role in the project (as is discussed in the issues and mid-term recs sections), then this would be a logical function for her to coordinate.

7. The education coordinator that has been working with the project for the last six months has really made a contribution to the program. She has adapted the training courses that were provided for trainers to the promoter level. These courses include LAM (MELA), Key Messages, Marketing Techniques, and Gender and women's rights. She also wrote the curricula and training plans for these courses. In addition she worked with the supervisors on their educational techniques and helped them to organize their presentations. All in all the quality of the educational content, methodology and participatory techniques have undergone a dramatic improvement since the mid-term. However, there is a need for continued education support, particularly in light of the new technical areas that will be added to the new project. There is a need for the continued development of training courses and for refresher courses as well as a need to further strengthen the supervisors educational skills. Therefore, the evaluators recommend that the new project contract an education consultant to continue strengthening this aspect of the project. (See issues section of this report for how this position would be structured).

8. Many of the promoters commented on the usefulness of the training courses, particularly the ones on key messages, capacitando sin letras and marketing techniques. However it is important to keep reinforcing these courses by holding regular refreshers and during monthly meetings with promoters.

9. While it was evident that project staff had more educational materials to distribute to patients and community members than were available at the mid-term, all the promoters commented that they could use more. At the time of the final evaluation, they were out of the CIES brochure that talked about family planning methods. They did have the CIES brochure about STDs and the CIES institutional flyer as well as several flyers about the FP methods produced by the IEC subcommittee. (The evaluators did not see the CIES logo on the subcommittee materials - which they can request that the printer add during the reprinting process). It would be useful for the project to buy quantities of the methods posters that are also produced by the IEC subcommittee to give to promoters to hang on their walls. It is recommended that as part of the DIP, the program set up a regular strategy and budget to assure a constant supply of educational materials.

5.2 STDs/AIDS CONTROL

Problem Statement

Regarding STDs, the CARE Baseline indicated that 5 1% of WRA and 75 % of men over age 15 (MRA) had heard of them, and could name at least one (Gonorrhea, Syphilis, Chancroid, Chlamydia, Herpes, Trichomonas, AIDS). Over a third of the women (37.7 %) and over half of the men (54.7%) knew that an STD can be prevented by one of the following methods: condom use, sexual relations with only one partner who is also faithful, or abstinence. CARE'S ethnographic study (1996) indicates that STDs are not considered problems that could affect one's family or community. It is interesting to note that many people did not connect STDs with sexual relations. Some did associate STDs with sexual relations, but believed they only occur among prostitutes. The level of knowledge of symptoms and prevention was low, and people tend to self diagnose and medicate themselves to treat a STD using home remedies or pharmaceuticals.

Proposed Strategy

The STDs/AIDS component strategy was to increase detection and treatment of STDs/AIDS by providing culturally sensitive education, counseling and referral services through the CIES clinic and increase prevention of STDs/AIDS through community outreach, community based and mass media IEC programs and the distribution of condoms by CBD agents.

Training was provided to project staff and CBDs in methods of transmission, recognition of signs and symptoms of STDs/AIDS and prevention. IEC messages to the public were provided through mass media, community education, mens groups, and to the Juntas Vecinales. Services for diagnosis and treatment were provided by the CIES clinic, and referral hospitals. Resources include condoms, educational materials and models, and medical personnel from the clinic and hospitals mentioned above.

Findings

The following chart compares the project objectives to the results of the baseline and final KPC surveys.

INDICATOR	GOAL	BASE-LINE 1995	KF'C JULY 1997	%In-crease
% of women of reproductive age who know that sexually transmitted diseases exist and who can name at least one	80.0	58.0	66.3	8.3%
% of men 15 years and older who know that STDs exist and who can name at least one	85.0	75.0	82.9	10.5%

INDICATOR	GOAL	BASE-LINE 1995	KPC JULY 1997	%In-crease
% of women of reproductive age who know that STD transmission can be prevented by using a condom, having sexual relations with one partner who is also faithful or abstinence	**75.0**	**38.0**	**60.3**	**22.3%**
% of men 15 years and older who know that STD transmission can be prevented by using a condom, having sexual relations with one partner who is also faithful or abstinence	**75.0**	**55.0**	**77.9**	**22.9%**

Achievements;

1) Knowledge about and ability to name one STD increased among women in the project area from 58 % to 66.3 % between the baseline and **final** survey.
2) Knowledge about and ability to name one STD increased among men in the project area from 75.3 % to 82.9 % between the baseline and **final** survey.
3) Knowledge that condoms, abstinence, or having one faithful partner can prevent the transmission of **STDs** increased among women from 38% to 60.3 % during the project period.
4) Knowledge that condoms, abstinence or having one faithful partner can prevent the transmission of **STDs** increased among men from 55 % to 77.9% during the project period.
5) All CBD workers interviewed could describe what **STDs** were, how they were contracted and what the basic symptoms were. Most knew that the person needed to be examined even if the symptoms had disappeared and that the partner had to be treated as well.
6) The evaluators observed the staff conduct educational sessions with community groups about **STDs** and their prevention. They used participatory methods and made good use of educational materials. They also distributed an educational brochure and the CIES flyer at the end of the session so that the participants could refer to a written example of the information presented and knew where to go for services.
7) CIES has a series of radio spots being broadcasted on Radio Panamericana and Radio Metropolitana which educate about **STDs** and refer to CIES for treatment. PSI is also running campaigns about condoms as a means of prevention of **STDs** and refers to CIES.
8) The education sessions discuss key messages about **STDs** which include: how **STDs** are transmitted; how they are not transmitted; the most known kinds of **STDs,** what the main symptoms of an STD are; habits that protect one from acquiring an STD; the need for the partner of an infected person to be treated; the importance of completeing STD treatment and the consequences if the STD is not treated.
9) The CIES clinic is the main referral point for a person who needs STD treatment.
10) CIES has an information system that tracks patients who are referred for STD treatment.
11) CIES staff conducted 146 community education sessions about **STDs** and AIDS during year 3 of the project. That doubled its goal of conducting 70 education sessions on **STDs**

during the year.

Concerns:

1) The major concern is that despite indications of an increased awareness among the population about STDs and evidence that there is an increasing rate of STD prevalence among the El Alto population, there has not been an increase in the number of STD cases referred at the El Alto clinic (see Annex G). The clinic director believes that the reason they are not seeing more STD referrals is because the laboratory diagnosis and treatment costs are too high.
2) It is unclear whether women in the project area understand that STDs in women are often asymptomatic and can effect their pregnancy and the baby during birth. Women who go for prenatal care are screened for some STDs but many babies are born at home and therefore the babies are not protected during the birth process.

Discussion and Conclusions

Effectiveness

What is impressive about the knowledge indicators noted above is that knowledge about STDs and how to prevent it has incresed significantly during the past 14 months, particularly among men. In addition to project educational activities, there have also been other media campaigns conducted by PSI and JHU/PCS which dealt with STDs and their prevention. In either case, the well designed education sessions and mass media spots conducted by the project have certainly contributed to these increased knowledge levels.

Relevance

As noted above the project activity is certainly contributing to increased knowledge in El Alto about STDs and their -prevention. The evaluators observed great interest in STDs and a big response when the supervisors conducted education about the topic. Condom use is up in the project areas compared to baseline. The use of the PAP as a method for diagnosing some STDs highlights a good way of integrating FP/RH/STD.

Recommendations

1. Would suggest that CIES review its STD laboratory diagnosis and treatment costs and try to find a lower cost solution. In discussions with USAID and the USAID funded AIDS project, the evaluators discovered that the AIDS project is able to obtain testing supplies and medications for treatment at very low cost. According to the information received, the tests cost one fourth what it is currently costing CIES to perform these tests. Would suggest that the CIES staff consult with USAID/B and with the AIDS project staff to

explore options for buying supplies at lower cost.

2. Given the STD prevalence in El Alto, would recommend that the obstetrical risk reduction component of the next project consider including an STD treatment and prevention section that addresses STD transmission during pregnancy and birth, particularly in light of the high number of home births in the area.

5.3 CONTROL OF DIARRHEAL DISEASES (CDD)

Problem Statement

The principal causes of infant and child deaths in Bolivia are diarrhea1 disease and respiratory infections, both of which are complicated by malnutrition. The 1994 DHS reports a two week diarrhea prevalence of 30% for the Altiplano Region. Although 81.6% of mothers who had a child within the last three years knew about ORS, only 39.6% of children age O-36 months who had diarrhea during the two weeks prior to the DHS had received ORT or additional liquids.

For both diarrhea and respiratory infections, however, the DHS found that residents of the Altiplano were least likely to take their child to a health service. Vaccination coverage in the Altiplano is low: only 29.7 % of children age 12-23 months had vaccination cards and only 34.4 % of those had complete immunization histories. While acute malnutrition is most prevalent in the valleys region, chronic malnutrition is more prevalent in the Altiplano (33% of children age 3-36 months were two standard deviations or more below the reference point (NCHS standard for height for age).

CARE's Baseline Survey (1995) indicated that 36% of mothers of children age O-23 months could recognize signs of dehydration as an indication that they needed to seek help, and 24% whose children had diarrhea during the previous two weeks used ORT packets or home solution during the diarrhea episode. CARE's Ethnographic Study' (1996) indicates that people attribute two causes for diarrhea: biological infection or supernatural/affective conditions. If the diarrhea is thought to be caused by an infection, a physician will be consulted. If, however, the cause is determined to be supernatural, a traditional healer will be sought out.

Pronosed Strategy

The principal strategy for the CDD intervention is education of mothers of children under two to provide adequate home management of diarrhea cases. Project staff and CBD agents were trained in correct diagnosis and treatment, who in turn provided education on control of diarrhea, including the recognition of danger signs for dehydration, correct dietary management, referral of severe cases, and distribution of ORS packets. CBD agents distributed ORS packets free of charge in their neighborhoods, and provided demonstrations of proper preparation and use. They provided information to clients and referral. Services were provided by the CIES clinic, RSH community oral rehydration units, and referral hospitals. Education and services were provided on an on-going basis. Resources include educational materials, ORS packets, and rehydration equipment at the CIES Clinic and referral centers.

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[1] Study on knowledge, attitudes and practices regarding family planning, STDs/AIDS and infant diarrhea in El Alto RSH Districts I and II, June 1996.

Findings

The chart below compares project objectives to the results of the baseline and final KPC surveys.

INDICATOR	GOAL	BASE-LINE 1995	KPC JULY 1997	% change
ALL MOTHERS WITH CHILDREN AGE O-23 MONTHS				
% of mothers who have used ORT	65.0	52.2	51.3	(.9%)
% of mothers who know that ORT is used to prevent dehydration	40.0	27.7	54.3	26.6
% of mothers who know how to prepare ORT packets correctly	64.0	51.0	57.3	6.3
% of mothers who know that it is necessary to give more fluids than normal when a child has diarrhea	30.0	19.7	45.3	25.6
% of mothers who can recognize signs of dehydration as an indication that they need to seek help	50.0	36.0	24.7	11.3
% of mothers who know it is necessary to give a child more food than usual when the child is recovering from an episode of diarrhea	55.0	46.7	47.0	.3
MOTHERS WITH A CHILD AGE O-23 MONTHS WHO HAD DIARRHEA DURING THE TWO WEEKS PRIOR TO THE KPC SURVEY				
% of mothers who are breastfeeding who breastfed the same or more frequently during the diarrhea episode	84.2 or more	84.2	86.6	2.4
% of children age O-23 months who were not exclusively breastfed who were given the same amount or more fluids than normal	75.0	62.7	70.7	8
% of children who were given the same amount or more food during the diarrhea episode	67.6 or more	67.6	73.6	6

Achievements:

1) The 1997 KPC Survey shows a 26.6 % increase for mothers who know that ORT is used to prevent dehydration.
2) The percentage of mothers who know that it is necessary to give more fluids than normal when a child has dehydration has increased by 25.6%.
3) Mothers' behavior during the recent diarrhea episode regarding continuation of breastfeeding, liquids and food is at good levels, although there has not been a significant increase.
4) There are 130 CBD agents active in educational and distribution activities for the CDD component.

5) There have been a total of 184 group community educational session of the control of diarrhea, over the life of the project.

6) The project has produced a manual for diarrhea control, to be used by CBD promoters.

7) A total of 4,526 ORS packets have been distributed over the three year period.

8) All the CBD agents interviewed could explain how to prepare and administer ORS.

9) The CBD agents indicated that they all received supervision visits from the CIES supervisor or were in contact with him/her at least twice a month. During the visits they received supplies, orientation and guidance from the supervisor. Lack of sufficient supplies was not a problem, since more packets could be obtained from CIES if the CBD agent ran out before the supervisor's next visit.

10) Community education given by project staff is based on participatory methods, and is complemented by demonstrations of ORS preparation. Flyers are distributed to encourage people to visit the CIES Clinic.

11) Radio spots on the use and importance of ORT help reinforce the messages given by project staff and CBD agents in the community.

12) Educational activities include information on prevention of diarrhea, the relationship between child nutrition and diarrhea1 disease, and the importance of using ORT and not antibiotics or antidiarrheal medicine.

13) The CIES Clinic provides basic nasogastric and intravenous rehydration treatment, has laboratory capability to determine the cause of the diarrhea, and can transport severe cases to referral hospitals.

14) CIES manages a good information system for the CDD program including indicators on number of cases seen, ORS packets distributed, referrals made to and from the CIES Clinic, and education sessions conducted.

15) Project staff, especially the field supervisors and the CBD agents interviewed impressed the evaluators by the dedication, commitment and importance they give to their work.

Concerns :

1) There has been no significant increase in the percentage of mothers who have used ORT (5 1.3 %) and know how to prepare it correctly (57.3 %). This means that approximately one half of the mothers in the project service area do not use ORT to treat cases of diarrhea in their children.

2) Only one fourth (24.7 %) of mothers can recognize signs of dehydration as an indication that they need to take their child to a health service.

3) Several of the CBD agents interviewed did not mention doing any follow-up of infants who had been ill with diarrhea.

4) When asked about advice given to mothers regarding referral of a child with diarrhea, several of the CBD agents did not mention recognition of danger signs as the criteria for seeking help.

5) Although the project promotes the CIES Clinic as a referral site and distribution center for ORS packets, educational messages do not mention other health services which may be

closer and more accessible to mothers.

6) Mothers of children under two have not been specifically targeted for education and follow-up activities by CBD agents.

Discussion and Conclusions

Effectiveness

The CDD component of the CSX project represents only 15% of project effort. The main focus of project activities is family planning, an area in which CIES has gained experience and expertise over the past 10 years. The CDD component is new for CIES, and therefore has been slower to mature than the family planning intervention. Diarrhea is a complex health problem due to the difficulty of implementing prevention strategies (sewage and water systems), cultural constraints regarding treatment, and the challenge of impacting behavior change in mothers in a rapidly growing and changing urban setting. As a first step in introducing CDD to CIES, the CSX Project has emphasized the use of ORS packets (not home mix or home available fluids), and the management of diarrhea. The CDD component was scheduled to begin during the fourth quarter of 1995, however activities were actually launched in March 1996. In spite of the above the CSX Project has made some inroads towards improving prevention and treatment of diarrhea during the past 18 months of project implementation.

In August 1996, an evaluation of the CDD component was done by Robert Quick, of the Centers for Disease Control and Prevention (CDC). His report cites several strengths which enhance the effectiveness of the CDD component including: community education, incorporation of neighborhood councils (juntas vecinales), provision of incentives for promoters, kind treatment, cleanliness and good organization at the CIES Clinic. Effective educational strategies include: attempts to provide consistent messages (critical to a project's credibility and success); the use of two-way communication in educational sessions; the use of local promoters to reinforce educational messages; the use of multilingual educational materials also appropriate for illiterate people; use of key messages which are easy to remember; working with existing groups and in local markets and fairs; and efforts to ensure coverage of all project zones.

The USAID Technical Review of the DIP mentions the importance of improving preventive efforts such as education on water, hand washing, latrine building and hygienic food management, and the inclusion of these messages in training modules. The CDC evaluation also indicates that the focus on treatment, rather than prevention, limits the potential impact of the project. Effectiveness is also limited by the fact that CBD agents have not targeted mothers of children under two years of age for education and follow-up. The project has not done a census to detect and single out these families for enrollment in CDD activities.

Prevention measures such as hygiene in the home and hand washing are included in educational messages, however prevention strategies, such as water and sanitation, were not included in this

intervention. Limiting the scope of the CDD component was appropriate due to the lack of experience in CIES, and the existence of other health services which provide education and treatment for diarrhea1 disease. Prevention of the transmission of diarrhea1 disease through improved hygiene will gradually take place, as the municipal government of El Alto installs sewage and water systems in outlying neighborhoods.

Relevance

The major causes of illness and death due to dehydration in the project service area include.: lack of potable water, poor or nonexistent sewage systems, lack of hygiene in and around the home, and inadequate management of diarrhea cases by mothers. The basic strategies implemented by the Project are sound: 1) provision of community education and referral of cases by CBD volunteers; 2) distribution of free ORS packets, and 3) radio spots explaining the cause and treatment of diarrhea.

However, it is not feasible for 130 volunteers to reach the mothers of 10,949 children, who will have a minimum of 3 episodes of diarrhea per year (32,847 cases), with educational activities, ORS packets, follow-up and reinforcement. Nor has the mass media presentation of CDD messages been sufficient to raise awareness and foster behavior change. In addition, cultural beliefs and costs of treatment are barriers to seeking help. Information gleaned during the Mid-Term Evaluation (1996) indicates that only a fraction of cases reach the RSH health centers and hospitals, especially for cases of mild to moderate dehydration.

In conclusion, CDD activities emphasize education of mothers regarding proper home management of diarrhea and training of CBDs to provide adequate diagnosis, treatment and referral. Although the Project does not emphasize prevention, both the community education and outreach strategies are relevant to the needs of the target population for information and guidance regarding basic practices to treat diarrhea1 cases in young children. The following section includes recommendations to improve the effectiveness and impact of CDD activities during the follow-on project: Market Networks for Community Health II.

Recommendations

1. Information from the ethnographic study (CARE, June 1996) should be included in training seminars for project staff and CBDs, to sensitize them to cultural beliefs. Educational techniques for teaching mothers about proper home management, which take into consideration cultural factors should be practiced during the training sessions.

2. In order for the CDD component to have more impact on mothers' knowledge and behavior, it is recommended that a census of all children under two years of age be undertaken in a pilot area, for the purpose of enrolling children in the program. The CBD agent(s) responsible for that area could keep an updated register of these children and a

map of where their homes are located. The families of these children, especially mothers, could be targeted for educational activities and home visits, including follow-up visits of ill children. The purpose of targeting mothers of children under two would be to give them extra attention and foster behavior change and hence proper home management of diarrhea cases. The recommendations of the evaluation of the CDD component (Quick 1997) should be taken into consideration, especially those related to self-efftcacy and improved education techniques. The successful elements of this strategy could then be expanded to other project areas. The families could also be targeted for family planning services.

3. The follow-on project will work with womens' groups using the WARM1 Methodology to reduce mortality from obstetric and neonatal emergencies. It is recommended that the new Project explore working through the womens' groups to register all children under two, and to include education on home management of diarrhea as a topic for the groups.

4. Training sessions for CBDs and key messages for mothers should emphasize recognition of dehydration danger signs, and encourage the mother to take her child to a health service. Staff should visit the health services in each project zone, and a relationship established for easy referral of children by CBD agents. The CIES Clinic may be too far or inaccessible for emergency care, given that the target area is quite extensive and transportation to some neighborhoods is not always available, especially at night.

5. The following recommendations regarding the work of CBD agents should be considered (Quick 1997):
   a. Develop a community based strategy for CDD activities.
   b. The development of a protocol for home visits to mothers of children under two, including preventive education and guidance for mothers who have sick children;
   c. Specific hours when neighbors can locate the CBD agent for help with a sick child;
   d. Recruit more CBD agents if there are not enough or they do not have time to attend to the targeted families;
   e. Develop a profile of ideal CBD qualities for the CDD component. Perhaps the best promotor for family planning or STDs, is not as well suited for diarrhea control.
   f. Develop a promoter's manual which could include: job description, suggested activities, rewards and stresses of the job, and suggestions for managing time.
   g. A flag indicating that the home of the CBD agent is an URO-P (Popular oral rehydration unit) could be used to advertise this service at the home of the agent.

6. Due to the large population and the extensive geographic area of El Alto, mass media should be used to promote proper home management of diarrhea in small children. The current radio spot is very well done, however the IEC program needs to be expanded to raise awareness, especially since the community outreach program cannot effectively reach over 10,000 children. (Could include interpersonal and popular media components.)

6
MANAGEMENT ISSUES

6.1 Budget Management

The cooperative agreement with USAID for the three-year Child Survival grant commits a total of $682,561. USAID provides 74%, and CARE has committed 26%. The rate of expenditures has varied substantially during the life of the project. During the first year only 19.28% of the budget had been spent, due to the slow process of consolidating a sub-agreement with CIES. Once the inter-institutional relationship was formalized, the Project began spending money, totaling 25.29 % for the second year. During year three, the Project was able to spend the remaining 55.43 % of the budget.

The financial problems during year two arose because CIES did not present financial reports in a timely manner, and CARE required extensive documentation with each report. In response to the recommendation of the Mid-Term Evaluation, CARE and CIES initiated a series of weekly meetings to iron out financial issues. An action plan was prepared which programmed line items, amounts to be spent, and dates. CARE streamlined their requirements for financial reporting from partners, and hired a financial manager to deal exclusively with CARE's projects in the La Paz region. CIES, in turn, hired an excellent Director of Finance, Gerard0 Calisaya, who worked closely with the Project Manager and Assistant Manager. Mr. Calisaya became proficient in the TECHAPRO financial management software program used by IPPF affiliates, and this has facilitated the generation of reports for several different donors. Both CARE and CIES are now in a good position to proceed with efficient financial management of the new CSXIII Project.

Amounts originally budgeted for in the Project varied somewhat over the three year period. Less money was spent on travel, consultants, and direct costs (field facilities and communications). The Project Manager supervised both the baseline and final KPC survey which waived the need for outside consultants, and she did not travel as much as planned. More funds were spent on personnel, procurement, and the sub-donation to CIES. A part time secretary was hired to assist

additional expenses were for supplies, educational equipment, and training. An extra 11.27 % was given to CIES, which was used primarily for field staff salaries and procurement. (See Annex H for a copy of the pipeline analysis.)

Recommendations

1. Continue with the current procedure for inter-agency budget management and financial reporting, including meetings between CARE and CIES finance staff on a regular basis. The new project will include changes in personnel responsibilities and full-time equivalents

which will require subsequent changes in the project budget (see Section 6.3 below). Both institutions should work together, in consultation with PSI, to make sure that all donor institutions are aware of the changes and reporting procedures.

6.2 Supervision

Supervision is provided to the five field supervisors by a Field Coordinator, Matilde Sanchez. The Field Coordinator, in turn, responds to the CIES Clinic Program Coordinator, Maria Elena Davalos. The field supervisors are responsible for the guidance, on-the-job .training, and supervision of the 194 CBD agents. The quality of their work is essential for keeping the-volunteer CBDs active and motivated. Due to recent personnel restructuring in CIES, and a relationship of camaraderie between the Field Coordinator and the field supervisors, the supervision system is somewhat weak. CARE has excellent experience in work with volunteers and supervision of field staff and could use this experience to strengthen this area.

Recommendations

1. The evaluators recommend that CARE organize an inter-institutional exchange of experiences to integrate the CIES Clinic Program Coordinator into project activities, and to provide training in improved supervision techniques for the Field Supervisor. Since the follow-on project will implement the WARM1 methodology, it is suggested that the CIES Coordinators travel to Potosi to learn about this methodology and learn supervision techniques from the staff of the PROMADRES II Project. Additional exchanges could be made with other CARE projects, as required.

2. Due to the large population of El Alto and distance between neighborhoods, CBD Supervisors cannot effectively reach all the areas nor attend to the 194 CBD agents with supervision visits. It is recommended that the Project consider elevating the star CBD agents to the level of "Facilitator". The facilitators could receive additional training and incentives, and take on some supervisory duties in specific geographic areas.

6.3 Project Structure and Management

During the past year there has been a change in the management structure of the project due to CIES's reorganization and the assignment of the CARE project manager to another project in El Alto (half time). According to the CIES Director and the CIES Assistant Program Manager, when CIES restructured, the Asst. program manager's job at CIES changed: she became the deputy manager for the CIES CBD program nationwide. She also oversees the regional office of El Alto and all its attendant services. As a result, the assistant program manager is no longer involved in the day to day activities of project implementation. As the national CBD manager, she still oversees reports and collects data for the project at the central level and she has continued interacting with the CARE program manager and provides her with reports about

program services, finances etc.

When this restructuring occurred, CIES also added a programs coordinator in El Alto. Her job was to manage and coordinate all the field programs run out of the clinic. These are the Community Doctors (medicos adjuntos), the adolescent program, social marketing, the GTZ funded STD activity and the CARE funded CBD program. Unfortunately, because the assistant program manager (now CIES deputy manager for the national CBD program) was still being paid by the project for 100% of her time, she continued to be viewed by CARE as the key staff person responsible for daily project activity in El Alto. So even though the new clinic coordinator for programs was supposed to be taking over the planning and daily management tasks for the CBD project, she was not recognized by project staff as having this role. The fact that she was being paid full time by PSI also prevented project staff from viewing her as the logical person to be coordinating the CARE project or the GTZ project.

Recommendations

1. The new project is going to be developing several new components, these include strengthening maternal health and preventing obstetrical risk, working with Community Doctors (medicos adjuntos), pharmacies and other new areas. In addition, project funding is going to be gradually reduced over the 4 year period. Therefore the management requirements are substantial. For this reason it is essential that CARE provide a full time project manager (or full time equivalent). This position is considered key staff by USAID. More about the project manager's role is discussed in number 2.

   Another key staff position is that of the CIES assistant project manager who is responsible for daily project activity. However, since the assistant manager now has multiple CIES responsibilities beyond the scope of the project, it is recommended that the project redistribute this management responsibility among different staff. The evaluators understand the importance of trying to integrate the project management with the CIES management structure, so we propose that daily project management tasks be coordinated among 4 individuals and that the this allocation be reflected in.the project budget and staffing plan. The following is a suggested breakdown of key staff: (Please remember that this is a suggestion to be further considered by project staff at the time of the DIP):

CIES sub-gerente de CBD:	10% - 20% time
CIES clinic coordinator:	50% time
Project technical advisor:	100% time
CBD Coordinator:	100% time

   With this breakdown of management responsibilities, the sub-gerente will still maintain contact with the El Alto managers and guide general directions of the program assuring that they are consistent with CIES policies. She will also review reports and assure

consistency of data collection activity.

The CIES clinic coordinator will assume daily management responsibilities for the CBD program. She will be responsible for long and short range planning and for reviewing results. She is also responsible for coordinating activities between the CBD program and all the other programs she manages. Since the CBD program intends to work more closely with the medicos adjuntos and needs to continue developing its social marketing skills, it is assumed that the clinic coordinator will facilitate this. She will also represent the project's interests at the clinic management level and at the central office level, lobbying for administrative support and other project needs. Given the importance of this position for the CARE/ CIES project, it is recommended that the clinic coordinator receive more orientation to CARE and its programs and strategies in Bolivia.

The project technical advisor will be assigned as a full time technical consultant to the project. Her job will be to continue strengthening the educational aspects of the program. She will work closely with the clinic coordinator, the coordinator and supervisors and the central level IEC sub-gerente to strengthen the education and promotion aspects of the program. There will be new technical components added to the new project (maternal health, obstetrical risk, WARMI training, training for medicos adjuntos and pharmacists) that she will need to develop. There is also a need to strengthen the CDD strategy as is discussed in the survey results section of this report. Since the technical advisor is not part of the regular CIES staff, part of her job will be to coordinate the activities of the project with the other CIES activities.

Finally the supervisor coordinator position will be strengthened so that she is overseeing the implementation of all the field work with promoters and the community education and promotion aspects. She will regularly coordinate with the technical advisor and the clinic coordinator. More about strengthening this position is discussed below.

2. **Project Manager:** Given the changing focus of the new project, it is logical that the role of the project manager will also be changing. If the project implements the project management structure suggested above, then the project manager will be relating to the sub-gerente for CBD and the clinic coordinator and probably the technical advisor, to monitor project activity and explore CARE and USAID mechanisms for supporting the project. During the DIP process for the new project, the CARE project manager will need to work out a series of specific benchmarks based on operational plans, objectives and strategies which the CIES managers will be responsible for implementing.

Given that CS project support will be gradually diminished over the four year period with CIES picking up the corresponding administrative and personnel costs, it is important that the CARE project manager begin assuming a role of promoting the project to other donors. CARE has a network of donors who support different activities and it will be

important to promote the CBD project achievements among potential donors including USAID/ Bolivia. In addition, it is recommended that the project manager keep USAID/ Bolivia informed on a regular basis about the status of management issues. The mission has made a commitment to CIES's institutional strengthening and has strongly encouraged the CARE - CIES partnership for this reason. They also support other activities which could provide support for this project such as the **AIDS** project and mothercare activity.

Another task that the project manager will be expected to perform is more interchange between this CBD project and other health projects that CARE is supporting in the country. In this way she will be introducing successful strategies that CARE has. implemented in other areas of the country to the project. Some specific suggestions regarding CARE experience which would be useful to this project are discussed in this section under supervision, and in other areas of the report regarding integration of the CARE WARM1 training for the maternal health part of the new project.

3. **CIES personnel policies for field staff:** An area that is discussed in other areas of the report is the need for CIES to review its policies for field staff. This is particularly important if CIES plans to make the CBD program an important national program. Certain policies which it has established for all staff would be more appropriate if they were adjusted for field purposes. For example, the evaluators would suggest that CIES revise its transportation reimbursement policy (see recommendations in FP section of Chapter 5). That they consider removing the transportation item from salaries and reimburse for travel. This strategy would encourage more travel to hard to reach areas. Would also suggest that CIES adjust its time card system for field staff. Since the fieldwork requires that staff often make visits at lunchtime or in the evenings, it would be more appropriate to use a system that does not require them to report into the clinic at these times. Would recommend that CIES consider shifting to a system that documents actual activities performed and results than worry about time schedules. In discussions with project staff, CIES will probably discover other areas that could be adjusted to facilitate the work of field staff. Much of this discussion will be the work of the sub-gerente for CBD and the clinic coordinator with the CIES personnel department.

4. **Pricing policies:** In a few instances it has come to the evaluator's attention that the prices of certain services have increased unexpectedly or are already too high for the audience being served. One of these is discussed in the STD recommendations in chapter 5, where despite increased awareness about STDs, the clinic is not seeing an increase in referrals. The clinic director thinks that this is because the laboratory diagnosis and treatment costs are too high. As is suggested in that section, CIES should consult with the AIDS project because they are able to buy large quantities of these supplies in bulk and dramatically cut costs. They also have other activities that might be useful to CIES, and they are returning to El Alto to re-start their work with the MOH there.

Another concern was that when the evaluators briefly interviewed some of the Community Doctors (medicos adjuntos) about participating in the follow-on project, they found that many of the doctors are unhappy with a recent contraceptive price increase. They claim that the prices are higher than the market value of contraceptives and that they can get them cheaper in the pharmacies. The medicos adjuntos coordinator said that she has not had one request for contraceptives since the price change, from any of her 25 regular doctors. Suggest that CIES evaluate this new policy and consider how this will impact the new project.

Another price related issue that arose was when the evaluators asked about the lower amounts of condoms and vaginal tablets distributed during the last year than had been projected, they were told that this was due to the higher costs of the products (see FP section of chapter 5). CIES stopped distributing the no logo condom in favor of the higher priced PANTERA. The vaginal tablets price increased from 10 - 20 centavos a piece to 70 centavos apiece (a 300% or tripling of the price). Whether this was the reason or whether the decrease was due to a having a more accountable and stricter logistics system in place is unclear but if price is an issue, then the situation needs to be followed to determine whether this is a temporary and correctable phenomenon or if it is long term.

5. **Clinic Reception:** After observing how hard the clinic and project staff are working to promote CIES and its services, the evaluators were disturbed to hear from promoters and community members that they were having problems with the clinic receptionist/ secretary. The promoters stated that they were often not connected with the supervisors when they called and received rude treatment. Community members complained of being turned away because they did not have the right change or their clinic cards, even when they were seriously ill. They also complained of rude treatment and stated that they had gone elsewhere for service. Later when the evaluators questioned clinic staff about this, they confirmed the problem.

This finding is a concern especially when the project is trying to increase referrals for FP, STDs and CDD. If the problem is simply administrative there are actions that can be taken to improve the situation. The secretary does have a tremendous amount of work. She keeps all the clinic accounts (three), handles petty cash for three projects, and handles the accounts for the four major donors in El Alto. All of these are handled separately. She is also responsible for handling all the operational expenses such as car maintenance and gas costs, clinic supplies etc. She is also in charge of getting all the estimates when they have to buy items that cost more than $100. and she totals the daily earnings, takes them to the bank and withdraws $bs 300 in small change for the next day. On top of these financial tasks, she is also expected to greet patients, collect the consult fee and answer telephones. Some administrative arrangements that might improve the situation include hiring an Aymara speaking receptionist to greet patients, sign them in and answer the telephone. Since no one in Bolivia ever has small change, it would also be advisable to pick up larger

amounts of small bills at the bank each day for change (instead of bs/ 300 in change, get bs/ 1000). The CIES administration department could evaluate this situation and probably come up with other administrative solutions. The Clinic Director is interested in having this kind of assistance. He spends a tremendous amount of his own time on administrative matters and noted that the secretary has been of tremendous support to him. However, if the problem has to do with the personal temperament and attitudes of the secretary, then CIES needs to evaluate whether it can afford to have this kind of person greeting its public, even to collect the consultation fees.

7
INNOVATIONS AND LESSONS

For both CIES and CARE, the child survival project in El Alto has been an important learning experience in workmg together in partnership. It has given CIES experience in working in diarrhea1 disease control and an experience base for implementing a nation-wide CBD program. It has provided CARE with experience working in urban areas, in reproductive health and further experience in implementing projects through partnerships. CARE has produced two "lessons learned" reports one by the project manager in March 1996 and the other by the finance manager in May 1996. The former addressed several issues faced by both institutions during start up and implementation and identified new issues to be resolved as the project continued. The latter report dealt mainly with the subagreement development process and the relationship with the CIES finance department. The CIES staff also identified lessons learned about strengths and weaknesses of the partnership in their self-evaluation workshops (conducted before the mid-term and the final evaluations). Currently the project manager is writing another lessons learned report which documents the many issues that arose and were resolved during the life of the CARE/ CIES partnership in El Alto.

CIES is using these lessons learned to strengthen and expand their CBD program throughout Bolivia. Care has been applying this experience in developing new urban programs and in working through partnerships.

Some of the innovations that have ocurred through the partnership include the improved project information system that CIES and CARE worked on together, several very well organized CBD training courses and documents to accompany them, as well as some innovative methods of integrating CDD distribution with contraceptive methods distribution at the community level.

What is interesting is that despite initial start-up and implementation problems, both institutions have remained committed to the partnership arrangement, and this will be continuing during the four year follow-on project. Perhaps one of the best innovations is having a large PVO support a local NGO and thus enhance the sustainability of project benefits over time in a host country. In addition, both institutions are learning new skills and applying them in their other projects throughout the country.